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CATASTROPHIC HEALTH INSURANCE: THE TENNESSEE PERSPECTIVE

HEARING

BEFORE THE

SUBCOMMITTEE ON
HEALTH AND LONG-TERM CARE

OF THE

SELECT COMMITTEE ON AGING
HOUSE OF REPRESENTATIVES

NINETY-NINTH CONGRESS

SECOND SESSION

MARCH 27, 1986, CHATTANOOGA, TN

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CATASTROPHIC HEALTH INSURANCE: THE TENNESSEE PERSPECTIVE

THURSDAY, MARCH 27, 1986

HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON AGING,
SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE,
Chattanooga, TN.

The subcommittee met, pursuant to notice, at 10 a.m., in banquet room A, Chattanooga Trade Center, Carter Plaza, Chattanooga, TN, Hon. Claude Pepper (chairman of the subcommittee) presiding.

Members present: Representatives Pepper and Lloyd.

Staff present: Kathy Gardner Cravedi, staff director, Subcommittee on Health and Long-Term Care; and Steve Hiatt, district administrative assistant, Representative Lloyd's staff.

OPENING STATEMENT OF REPRESENTATIVE MARILYN LLOYD

Mrs. LLOYD. I want to thank all of you for being here today as part of this overflowed crowd. It is certainly a great honor for me, as your representative, to be able to conduct these hearings here and to have your participation.

Certainly, it is a pleasure personally and professionally to introduce this great man who is with us today. He is a man that bridges every generation in the 20th century. He is a legendary figure in his own time, a time that includes over five decades of public service. This man is a product of a very humble American dream come true.

He is a self-made man without peer. He is a lawyer. He is an educator. He is a statesman. He is an author. But, above all, Claude Pepper is a humanitarian, and I think that he has done more than anyone living today to dignify the meaning of life for young and old alike.

You know, serving with Claude Pepper has been an awesome experience for me because he is a man of enormous energy and talent, and he is driven by a great sense of duty to his country, as well; but he is also a man who brings to the legislative process the wisdom of hindsight and certainly the vision of foresight.

He is a man whose vitality of mind, body and spirit really defies all the myths about old age, and it is certainly a wonderful pleasure to introduce to you someone that I truly love. He is one of the most beautiful individuals that I have ever known in my life.

Would you join me in welcoming Hon. Claude Pepper.

STATEMENT OF CHAIRMAN CLAUDE PEPPER

Mr. PEPPER. Mrs. Lloyd, your probity and veracity, I am sure, has never been questioned before. But when the press records that you have described Claude Pepper as beautiful, I do not believe they are going to believe you.

You were very beautiful to say those kind words. It is a great privilege for me to be here with you today. This is one of the great Members of the Congress of the United States.

At the end of last year, I had been in the United States Congress 37 years—14 years in the Senate, from 1936 until 1951, and then 23 years in the House of Representatives. There are some people who say that the quality of our representation in the U.S. Congress is not as good as it used to be. However that may be, there has never been a representative of higher quality of mind and conscience and compassion than Marilyn Lloyd, your great representative here.

She is conscientious, hard-working, comes home every weekend to be in contact with her people trying to find out what they want her to do. She is the kind of person who wants to do right.

A little bit ago, as you know, we voted in the Congress on what to do in Nicaragua. Marilyn Lloyd was not satisfied just to read what she could read and hear what she could hear. She and a few others went down to the area around Nicaragua and interviewed all the top officials. She said, "tell us what you all think down here, in the area of Nicaragua, what our country should do?"

She has gained valuable information that I am sure she will employ when the matter comes up for another vote in the next few days. But that is typical of the determination of Marilyn Lloyd, to know the truth and to do right in the service of her beloved country.

I had another great pleasure here today, to meet her wonderful mother, Mrs. Laird. I told her she gave me something to shoot at. I told a little story about a fellow who was in the business of producing chickens and eggs, including Bantam chickens and eggs. One day he was showing a friend through his chicken business and he came to a little Bantam hen that was sitting there with her little eggs in her nest. Right in front of her, they had an ostrich egg, and the visitor said to the proprietor, "What in the world is that ostrich egg doing there in front of that little Bantam hen?" He said, "Just to give her something to shoot at."

Well, I told Mrs. Laird this morning—she is 91 and I am a mere 85—she gives me something to shoot at, and how wonderful it is—there is Mrs. Laird, right here; you have just seen her—how wonderful it is to elderly people, and I see so many people in this wonderful audience today who, like Mrs. Laird and I, are still active and still vigorously contributing to their community and to their country.

The first time any member of my family came here to the area of Chattanooga was when my father's father came here in the Battle of Chickamauga. As a little boy, I used to hear my grandfather talk about the Battle of Missionary Ridge. So, when Marilyn and I were driving in from the airport yesterday evening, she pointed out to me where Missionary Ridge was.

The last time I was here personally was to be with another great Tennesseean, Senator Estes Kefauver. I spoke with Senator Kefauver here in Chattanooga and spent the night with some wonderful people, who were connected with the local paper, at their lovely home up on Lookout Mountain.

So, I am glad to be back here today to talk about a bill that Marilyn and I have introduced, the design, and we believe the effect, of which will be—if adopted—to provide better care for the elderly people of this country against catastrophic costs attributable to catastrophic illness.

When I was born, in 1900, only 5 percent of the people were over 65 years of age. Now, 11 percent of our population are in that category. And in less than 50 years, almost 20 percent of the American people will be over 65 years of age. Strangely enough, and interestingly enough, for people like Mrs. Laird and me and many of you, the group that is growing percentage-wise the fastest is the group over 85.

So, it shows that people are living longer. It is not a rarity now, too much so, to find someone like this wonderful Mrs. Laird who is still active and vibrant and vigorous in her activities at over 90.

I had a hearing before our committee in Washington a year or two ago. We had seven witnesses, and every one of them was over 100. As a matter of fact, there are 15,000 people in the United States today who are over 100 years old. But of those seven, a lady was the youngest, 100. A black man who had been a fireman on a railroad locomotive was the oldest, 112. We arranged for an aide to accompany each one of them from his or her home to the hearing in Washington.

After the hearing was over, I had them over to the Capitol dining room as my guests. We had a delightful luncheon. Some of them shared a glass of wine with me. We told some stories and had a very pleasant little time together, and they separated and went on back to their homes. All of them were over 100 years old. We had a witness, a very beautiful young little lady, 98, not long ago, who was an excellent, outstanding witness before our committee.

But the elderly people have had the cost of their medical care increased 100 percent in the last 10 years. In 1965, we adopted in the legislature what we call medicare today. It is a part of the overall Social Security Program. It provides primarily curative care; that is, the kind of illness that requires hospitalization and medical care from a doctor.

Now it has provided a very helpful, a very meaningful service to the elderly people. But it only covers about 45 percent of the medical costs that the elderly people sustain. It does not cover long-term illness like, for example, Alzheimer's disease.

Incidentally, not long ago we used to think of Alzheimer's disease as senility. They think old folks are just getting old and senile. Now we know that is not true; that elderly people in general are as alert and sometimes even more alert than younger people.

The brain continues to grow. But Alzheimer's is a disease, and it is the fourth largest killer in our country today. Then there are debilitating illnesses like Parkinson's disease and, of course, arthritis and the like; severe heart disease and some kinds of cancer.

Furthermore, the medicare system of today does not cover drugs that one consumes in the home or outside of the hospital, even if prescribed by a doctor. Elderly are billed at $2 to $3 billion a year because those drugs are not covered. That is a very big burden upon the elderly people.

In addition to that, medicare does not cover eye care or eyeglasses or hearing aids, and these hearing aids cost $400, $500, $600 a pair. A lot of people do not have the benefit of glasses or hearing aids because they cannot afford it. That is not covered by medicare.

In addition to that, medicare does not cover foot disease or foot care and a whole lot of other things that are meaningful to the elderly people.

So, what Mrs. Lloyd and I began to consider was, is there some way that we could maybe re-channel the money that is now being spent by the elderly and by the Government without it requiring the expenditure of any more money, without imposing any additional financial burden upon the elderly or the Government? Can we not use private enterprise more effectively and get more efficiency in administration? Can we not do a better job with the same amount of money that is being employed in the Social Security Program under which you pay in a certain amount of your social security contribution to medicare, and then you pay in another tax to the doctor's part, part B of medicare?

We know that medicare does not cover everything adequately—all of the medical needs of the elderly. We have what we call medigap insurance to try to cover the deficiency in the Medicare Program.

So, Mrs. Lloyd and I figured that if we just put all our health dollars together and re-channel them, can we not get better results with the same amount of money? That is basically the aim and purpose of the legislation we will talk about today.

Now, the administration a little bit ago pleased us very much by announcing through its new Secretary of Health and Human Services, Dr. Bowen, that it believes in catastrophic insurance. That is exactly the purpose of our bill—catastrophic insurance.

But then we had Dr. Bowen come down and testify before our subcommittee. He made a good witness. He told us what he was doing. And we said, "Dr. Bowen, that is fine; you would make it possible for an elderly person to stay more than 2 weeks in a hospital, and the program would pay for that extra time over 2 weeks. But you would ask them to pay—36 million people to pay $15 a month to get that, and it would benefit only one-tenth of 1 percent of the elderly people covered by Medicare."

So, we said, "Doctor, can we not do something better? Will you take a look at a bill Mrs. Marilyn Lloyd and I have introduced to see if we cannot give comprehensive care coverage to the elderly on these great costs?" It is nothing today to get a hospital bill of $50,000 or a hospital or medical bill of some enormous amount. Even the middle class today is not secure against being bankrupt.

Suppose you got the tragic advice that I received one evening from a doctor: Your wife has cancer. It cost me $40,000 just for extra nursing to give my dear wife the best of care that we could give her, and that was just a part of it.

Suppose then the husband has a serious illness with the heart. That $50,000 or $75,000 or even $100,000 that he has got saved in liquid assets would be gone in a little bit, and maybe the home, too, before it is all over.

So, the demand today from the people is that we have got to find some way more efficiently and more effectively to take care of the exorbitant costs of illness today, especially for the elderly.

I do not want to take too much time away from the witnesses here who have come here to tell us today what would be the meaning and the significance of our program. I would like for Mrs. Lloyd to add to what I have to say, but it is neutral cost. We do not add any new costs; we just re-channel the money already being spent, we think, through private channels into more effective use.

So we hope you are going to be interested in our program, and hope you will let it be known that it seems to strike a great need with you and to the goodwill with the hope to ensure our being able to get this matter through Congress before very long.

Now, may I ask that Mrs. Lloyd——

Mrs. LLOYD. Thank you. Thank you very much, Mr. Chairman.

Since these folks hear from me about every weekend when I am home, I think that I will ask unanimous consent to put my remarks into the record, and we will go on with our hearing.

Thank you.

[The prepared statement of Representative Lloyd follows:]

PREPARED STATEMENT OF REPRESENTATIVE MARILYN LLOYD

MRS. LLOYD. THANK YOU, MR. CHAIRMAN. WE IN TENNESSEE ARE HONORED TO HAVE YOU WITH US TODAY FOR THIS HEARING. WE APPRECIATE YOUR GIVING OUR OLDER CITIZENS AND COMMUNITY OF HEALTH CARE PROFESSIONALS THE OPPORTUNITY TO PRESENT THEIR PERSPECTIVE ON THE NEED FOR A NATIONAL CATASTROPHIC HEALTH CARE PLAN.

AS ONE OF THE ORIGINAL MEMBERS OF THE SELECT COMMITTEE ON AGING, IT HAS BEEN A PRIVILEGE FOR ME TO WORK WITH YOU IN ADDRESSING THE PROBLEMS OF OLDER AMERICANS. THE COMMITTEE HAS BEEN A VERY EFFECTIVE FORCE IN IDENTIFYING, AND DEVELOPING A LEGISLATIVE RESPONSE TO, THE SPECIAL NEEDS OF OLDER PEOPLE.

TODAY WE ARE FOCUSING ON A NEED WHICH, IN SPITE OF OUR BEST EFFORTS OVER THE YEARS, HAS YET TO BE FULFILLED. IT IS A NEED THAT WAS JUST RECENTLY RECOGNIZED BY THE PRESIDENT IN HIS STATE OF THE UNION MESSAGE TO THE CONGRESS AND THE AMERICAN PEOPLE. AND, IT IS A NEED THAT WILL BE DOCUMENTED HERE TODAY BY THE TESTIMONY OF PEOPLE WHO HAVE HAD TO COPE WITH IT IN A VERY PERSONAL WAY.

I WOULD LIKE TO EXTEND TO THOSE WHO HAVE AGREED TO PARTICIPATE IN THIS HEARING MY APPRECIATION FOR THEIR HELP IN ILLUSTRATING THE DIMENSIONS OF THE GAPS IN HEALTH CARE PROTECTION FOR OLDER AMERICANS.

MOST ELDERLY AMERICANS RELY ON MEDICARE AND/OR A COMBINATION OF MEDICARE AND MEDIGAP POLICIES FOR PROTECTION AGAINST THE RISK OF ILLNESS. WHILE THESE PLANS MAY PROVIDE ADEQUATE COVERAGE FOR ACUTE ILLNESSES OF LIMITED DURATION, THEY OFFER LITTLE IF ANY PROTECTION AGAINST THE RAVAGES OF CHRONIC AFFLICTIONS THAT REQUIRE LONG-TERM CARE.

FOR EXAMPLE, MEDICARE AND PRIVATE INSURANCE PROVIDE LITTLE HELP FOR THE VICTIMS OF ALZHEIMER'S DISEASE AND OTHER PERMANENTLY DISABLING OR TERMINAL ILLNESSES THAT INVOLVE EXTENDED CARE AND TREATMENT. MOST FAMILIES HAVE THEIR HANDS FULL JUST TRYING TO COPE WITH THE EMOTIONAL STRAINS OF CARING FOR A LOVED ONE WHO HAS BEEN STRICKEN WITH A CHRONIC DISEASE OR ILLNESS. WHEN YOU ADD TO THIS STRAIN THE COST OF PROVIDING CARE THAT IS NOT COVERED BY INSURANCE, THE COMBINATION CAN HAVE "CATASTROPHIC" CONSEQUENCES FOR THE FAMILY. AND, WHEN THE FAMILY'S RESOURCES ARE EXHAUSTED, THE BURDEN IS THEN PASSED ON TO THE COMMUNITY. EVEN THOSE WHO CONSIDER THEMSELVES FINANCIALLY SECURE CAN BE PAUPERIZED BY THE COST OF PROVIDING UNINSURED CARE FOR THEMSELVES OR A LOVED ONE OVER AN EXTENDED PERIOD OF TIME.

MOST OF US WORK HARD ALL OF OUR LIVES TO BUILD OUR OWN "SAFETY NET" FOR RETIREMENT. WE WANT TO BE INDEPENDENT. WE DO NOT WANT TO BE A BURDEN ON OUR FAMILIES OR OUR COMMUNITIES. OUR "SAFETY NET" IS USUALLY STRONG ENOUGH

TO SUPPORT US SO LONG AS WE CAN STAY IN RELATIVELY GOOD HEALTH. WE STRIVE TO KEEP OURSELVES FIT BECAUSE WE KNOW THAT IS THE KEY TO OUR INDEPENDENCE.

WHAT MOST OF US FEAR MORE THAN DEATH, IS THE THREAT OF A MENTALLY OR PHYSICALLY DEBILITATING ILLNESS OR DISEASE THAT COULD DESTROY OUR "SAFETY NET" AND WITH IT THE QUALITY OF LIFE THAT WE HOLD DEAR.

IF WE AS A SOCIETY TRULY BELIEVE THAT HAVING ACCESS TO APPROPRIATE AND AFFORDABLE HEALTH CARE IS AN AMERICAN RIGHT, THEN IT IS TIME FOR US TO RECONCILE OURSELVES TO THE FACT THAT WE HAVE A LONG WAY TO GO IN MEETING THAT PROMISE.

WHILE THE PRESIDENT RECOGNIZED THE NEED FOR CATASTROPHIC HEALTH CARE IN HIS STATE OF THE UNION MESSAGE, THERE ARE DISTURBING REPORTS THAT THE MILLION MEDICARE BENEFICIARIES, AT THE EXPENSE OF EVERYONE IN THAT GROUP WHO WOULD BE ASKED TO DOUBLE THEIR ANNUAL PREMIUMS. ANY PLAN THAT DOES NOT INCLUDE FINANCIAL ASSISTANCE FOR THOSE WHOSE CARE MUST BE PROVIDED IN THE HOME OR IN A CUSTODIAL NURSING CARE SETTING, DOES NOT MEET THE TEST OF A CATASTROPHIC HEALTH CARE PLAN FOR THE ELDERLY --- SINCE THIS IS WHERE THE REAL NEED EXISTS.

THAT NEED IS RECOGNIZED HERE IN THE CHATTANOOGA-HAMILTON COUNTY AREA WHERE 28 AGENCIES HAVE JOINED TOGETHER IN A COOPERATIVE ARRANGEMENT THAT SEEKS TO COORDINATE COMMUNITY SUPPORT SERVICES FOR THE ELDERLY THROUGH A CASE MANAGEMENT SYSTEM APPROACH. WHILE SERVICES SUCH AS HOMEMAKER ASSISTANCE, ADULT DAY CARE, TRANSPORTATION, HOME-DELIVERED MEALS, HOME HEALTH CARE, ETC., ARE AVAILABLE IN OUR COMMUNITY, IT WAS FOUND THAT MANY OLDER ADULTS WHO ARE IN NEED OF HELP EITHER DO NOT KNOW WHAT IS AVAILABLE, OR THEY DON'T KNOW HOW TO GO ABOUT ARRANGING FOR THESE SERVICES.

AS A RESULT, MANY FRAIL ELDERLY WITH MULTIPLE PROBLEMS LEAVE THEIR HOMES FOR NURSING HOMES, RESIDENTIAL CARE, OR SOME OTHER INSTITUTIONAL SETTING PREMATURELY.

THE 28 ORGANIZATIONS INVOLVED IN THIS PROBLEM-SOLVING WORK AGREED THAT A CASE MANAGEMENT SERVICE IN CHATTANOOGA WOULD BE THE SINGLE BIGGEST HELP FOR OLDER ADULTS WHO HAVE NEEDS WHICH CAN BE MET AT HOME IF THEY KNOW HOW TO GO ABOUT ACCESSING AVAILABLE SERVICES. THEY ALSO FELT THAT IT CAN HELP PROVIDER AGENCIES, CHURCHES, FAMILIES, AND OTHERS WHO WORK WITH OLDER ADULTS IN THESE TYPES OF SITUATIONS.

AT A TIME WHEN FEDERAL DOLLARS ARE SHRINKING --- THE PUBLIC, VOLUNTARY AND PRIVATE ENTERPRISE SECTORS ARE WORKING COOPERATIVELY IN CHATTANOOGA TO FIND NEW WAYS TO FINANCE SUPPORT SERVICES WHICH ENABLE FRAIL OLDER ADULTS TO REMAIN INDEPENDENT.

LOCAL INITIATIVES OF THIS TYPE ARE AN IMPORTANT PART OF THE EFFORT TO BRIDGE THE GAPS IN OUR HEALTH CARE DELIVERY SYSTEM. THEY COMPLEMENT WHAT

WE ON THE AGING COMMITTEE ARE TRYING TO DEVELOP IN THE WAY OF A NATIONAL RESPONSE TO THE OMISSIONS IN MEDICARE AND MEDICARE-RELATED INSURANCE PLANS.

THEY ALSO DEMONSTRATE THAT PUBLIC AND PRIVATE AGENCIES RECOGNIZE THE NEED FOR A COMPREHENSIVE APPROACH TO PROBLEMS THAT CAN BE POTENTIALLY CATASTROPHIC FOR THE ELDERLY AND THEIR FAMILIES, AND THAT THERE IS A LIMIT TO WHAT CAN BE EXPECTED FROM WASHINGTON DURING THESE TIMES OF BUDGETARY RESTRAINT.

AND, NOW MR. CHAIRMAN, I AM SURE THAT YOU ARE AS EAGER AS I AM TO HEAR FROM THE WITNESSES WHO ARE PATIENTLY WAITING TO GIVE US THE BENEFIT OF THEIR TESTIMONY.

Mr. PEPPER. Today we have two panels. Panel 1, are victims of catastrophic illness.

Mrs. Nancy Broyles is the wife of an Alzheimer's disease victim in Chattanooga.

Incidentally, I held a hearing last year with Senator Gore at one of your medical schools. We had a great many people. Both Senator Gore, Mrs. Lloyd, and I have introduced a bill to provide 20 treatment and research centers in Alzheimer's disease over the United States. So we are very much concerned about this tragic illness of Alzheimer's disease.

So, our first witness is Mrs. Nancy Broyles. As I call your name will you please come up and take the seat by your name.

Next is Mrs. Mary Liddell. Mrs. Liddell, if I may say so, is 88 years old, legally blind. She is a breast cancer patient of Chattanooga, and is accompanied by Ms. Bobbie Wadel.

We are working toward a program under which every woman in America will be able to get a test for breast cancer before the lump forms, which indicates that the cancer is already advanced. This is one of the things about which we are very much concerned.

Next is Mrs. Ola Pope, 76, wife of a stroke victim, who has also contracted cancer. She is from Oak Ridge, TN.

First we will have Mrs. Nancy Broyles. I want to express to Mrs. Broyles my very great gratitude to you for coming here today to help in making the public aware of the seriousness of this problem, and encourage the public to support us in our efforts to do something about it.

Mrs. Broyles, we would be pleased to have you proceed.

PANEL ONE—VICTIMS OF CATASTROPHIC ILLNESS: CONSISTING OF NANCY BROYLES, WIFE OF ALZHEIMER'S DISEASE VICTIM, CHATTANOOGA, TN; MARY LIDDELL, BREAST CANCER PATIENT, CHATTANOOGA, TN, ACCOMPANIED BY BOBBIE WADEL; AND OLA POPE, WIFE OF STROKE VICTIM, OAK RIDGE, TN

STATEMENT OF NANCY BROYLES

Mrs. BROYLES. Thank you, Representative Pepper, Representative Lloyd, distinguished guests, ladies and gentlemen, my name is Nancy Broyles.

My husband, Prince F. Broyles, was diagnosed with Alzheimer's disease in 1979 at the age of 54. By 1981, he could no longer converse with people, make any decisions, or care for himself without assistance. Without his leadership, our business—a supermarket which we had operated for many years—had to be sold. Consequently, a portion of the proceeds from the sale was lost when the buyer filed for bankruptcy. My husband is now 61 years old and has been completely unable to care for himself for the past 5 years. He is now confined to a nursing home. Until late 1985, I kept my husband at home. When my husband reached the stage where he could no longer stand, sit, or turn when asked, it became necessary to place him in a nursing home.

I kept my husband at home because I felt I had no choice. I was informed that he could not be admitted to a hospital with a diagnosis of Alzheimer's disease. I was informed that my health insurance would not pay for any nursing home expenses which were not considered "skilled nursing care." The type of care necessary for my

husband is called "custodial or intermediate care." I was unable to receive Federal assistance because the Federal agencies do not consider Alzheimer patients to be eligible for such care. My alternatives were either to (*a*) place my husband in a nursing home and pay the full amount of all his charges; or (*b*) continue to keep him at home.

I kept him at home, to the limit of my mental and physical endurance. My husband is hopelessly incontinent. He cannot speak coherently. He is unable to follow the simplest instructions or comply with my requests. He is 6 feet, 6 inches tall and weighs approximately 260 pounds. Due to his incontinence, he had to be turned and/or changed about six times a day. In order to keep pace with his requirements, I had to do at least three loads of wash per day to keep him in fresh bed clothes and other personal clothing. I, of course, prepared meals, I fed him three times a day, and I administered his medicines according to the instruction of his doctors, and gave him company, which seemed to soothe his unrest. I could not get help from any local home health care agencies because the illness was not covered by medicare. I tried to hire people privately, but could not keep dependable help because of the low pay and hard work. I also suffered at his loss of dignity and the loss of his personality.

In all, I truly lived a 36-hour day in order to provide my husband the most basic needs--food, cleanliness, and love. At the advice of friends, family, and my husband's doctors, I tried placing him in a nursing home with myself paying 100 percent of the cost. I soon brought him home again because I found I was paying about $1,700 per month and was still having to provide a majority of the care for his needs due to his size and his condition. Eventually, as I have said, I had to return him to a nursing home for my own physical and mental well-being. I presently pay $1,600 per month for his nursing home care, and still I do his laundry and perform a considerable amount of his care.

I would like to add something to the subcommittee, if I might. I received a letter yesterday advising me that the nursing home charges ar going to go up $3 more a day, which is $90 a month.

Do not misunderstand me; I do not begrudge the smallest act which I perform for my husband. What I do for him I do because of love and obligation created by love. I am here today, however, because I am sad and angry that America's health care system is in the shape that it is. I am sad because of the heartaches and hardships created by my husband's medical bills. As I have said, I pay 100 percent of his bills. My private insurance, which I obtained out of what I thought was prudence and concern for the future, does not pay my husband's charges because he is receiving the "custodial or intermediate care," even though it is beyond my power and the power of my family to provide him even that level of care. My husband is ineligible for Medicaid because he has assets worth more than $1,500. That amount, as you all know, is far less than the value of a used car these days.

So, since private insurance will not pay, and since my husband is ineligible for meaningful government assistance, I must pay his expenses from our savings. The savings will soon be depleted, and the money which was meant for our retirement and as a cushion

against further misfortune will soon be gone. My husband's prognosis is good, or bad, depending on how you look at it. He can live another 5 to 10 years because of his young age and his good physical condition, which brings me to why I am angry.

I have sold a car, a boat and a piece of property just to meet expenses. And, as I have said, he cannot qualify for Medicaid because he has assets over the allowable $1,500. I have very little left to sell. I am past my peak earning years, but I can earn enough to support myself. His Social Security check pays only about a third of his monthly expenses, so I cannot earn enough to make up the difference. There is simply no way under our present system, to my knowledge, that I could have avoided any of this. No matter what precautions I could have taken, I would still (*a*) have no help from private industry; (*b*) my husband would still be ineligible for Federal assistance; and (*c*) I would still be physically and mentally unable to keep him at home.

The plain fact is, ladies and gentlemen, that it costs too much for the average individual in this country today to sustain himself, much less a family, through the catastrophic illness or health crisis of a loved one. I have no answers to this problem.

It would be helpful if Medicare and Medicaid eligibility were broadened to include the middle-class Alzheimer patients like my husband, or if our Nation's private insurers would take a realistic stance on what is "skilled care" and what is "custodial and intermediate care."

Whatever the solution, consider this a call for help—from me and from all of those who share the situation of my family, but who have not had the opportunity to be heard.

Thank you very much.

Mr. PEPPER. You make a very dramatic statement, Mrs. Broyles, and that is what we are concerned about with this legislation right here.

Before we have any questions, if we may, we will next have the statement of Mrs. Mary Liddell. She is legally blind and is a breast cancer patient from Chattanooga, accompanied by Ms. Bobbie Wadel.

STATEMENT OF MARY LIDDELL, ACCOMPANIED BY BOBBIE WADEL

Ms. WADEL. Good morning. My name is Bobbie Wadel. I am a registered nurse with Hospice of Chattanooga, a nonprofit agency for the care of terminal patients.

I have provided care for Mrs. Mary Liddell for the past 14 months. Mrs. Liddell is 88 years old. She was diagnosed in 1972 with breast cancer and in 1983 with bone metastasis. Mrs. Liddell lives alone in her apartment. Hospice made it possible for her to remain in her apartment throughout the course of her illness.

Due to a decline in Mrs. Liddell's condition, she is unable to be here today, but has provided a written statement. I would like to read that statement at this time.

I am an 88-year-old, and have known for some time that I am on my way out. My hope is to reach the end right here at home. For the past 14 months, I have been blessed with the help of Hospice. This has enabled me to use my own waning

strength as comfortably as possible here where I can rest in my own surroundings with familiar sounds and sights and neighbors nearby.

Each week, the Hospice registered nurse visits me, shares my problems, and gives me advice and comfort. She, in turn, reports to my doctor, who is there when I need him and who prescribes my medication.

For the past 9 months, I have been on a Monday-Wednesday-Friday schedule when I have a Hospice home health care aide who gives me baths, rubdowns, shampoos, and is willing to provide other help as I need it. My volunteer visitor from Hospice has become a dear and valued friend, helpful in many ways.

Wish me well.

In addition, I would like to add that due to medicare guidelines for home health, certain elements of care, such as monitoring of a patient's general condition, her safe home management, especially when alone, and emotional support and counseling, which is a large part of hospice care, are not reimbursable. As a result, the total charges for Mrs. Liddell's care for the past 14 months have been $8,061.68. Medicare paid $2,868.75. Hospice of Chattanooga absorbed the cost of $5,192.93, which was unable to be paid by the patient.

This is not an isolated case within our agency. Approximately 40 percent of care provided is nonreimbursable. Hospice has only been able to do this through private fundraising efforts.

I hope you find this information helpful. Thank you for your time.

Mr. PEPPER. Thank you very much, Ms. Wadel, for your excellent statement.

Now we have the next witness, Ola Pope, 76 years old, wife of a stroke victim who has also contracted cancer. She is from Oak Ridge.

Mrs. Pope, we are pleased to hear you. Speak right into the microphone, please.

STATEMENT OF OLA POPE

Mrs. POPE. Thank you, it is a pleasure to be here today. My husband, 3 years ago, December 28, 1982, was 77 and had a major stroke that left him completely paralyzed and without speech. We tried to keep him at home as long as possible and did for 14 months.

After the first hospitalization, he went into the nursing home for about a month. Then he returned to the hospital because of pneumonia and they found that he had a decaying gall bladder that needed surgery. We took him home and the health care—home health care agency staff came into my home and helped 3 days a week, assisting him with his personal care and a nurse was on call to come anytime. Without their help we could not have kept him at home. We would have had to place him in a nursing home.

The bills stacked up and we finally made some arrangements to get him in a nursing home when he got worse and was having seizures and things we could not control. It took day and night to help with nursing and all the things that we had to do for him. The doctor told me it was for his best interest and my best interest to put him in a home.

The nearest Medicaid bed available was about 17 miles from Oak Ridge. I drove it, a round trip 34 miles, seeing him and helping him every day. Then he had another stroke and went back to the hospi-

tal. Medicare would pay for his skilled care needs and so we put him back in the nursing home.

Riley is now there in the nursing home. If I could get the support service such as nurse's care to bring him home, I would be glad to keep him home because that is their desire to go home. Thank you for this chance to of tell my story because I am certain there are lots in my situation. Riley is now 80 years old and I am 72. We worked all our adult lives, but it did not take it long to go down because I have two bottles of little pills that they prescribed for him when he was at home. One of them was $52 and the other one $54 and he only took two pills. They didn't help me with his medicine at home or ambulance bills or those things, but we are sure we are going to get some better help. Thank you.

Mr. PEPPER. Thank you very much, Ms. Pope. In the case of all three drugs that were prescribed by a doctor, were not covered by Medicare. You had to pay for them? That's correct, is it not?

Ms. WADEL. Yes.

Mr. PEPPER. Now if you had been able to have kept the ill person in the home and the drugs could have been provided for under some public program and if you could have had assistance of trained and other personnel needed to care for that individual, could you have kept the ill individual at home?

Mrs. POPE. That is where they are so happy at, too, at home. They are lost to put them away and they are never happy and I think happiness is the way to health.

Mr. PEPPER. In each case the ill individual had a home, did you not? In the cases you told us about you had your own home?

Mrs. POPE. Yes.

Mr. PEPPER. In the three cases here today all of you had your own home. So it was not necessary to pay rent on another building somewhere for the individual to be cared for if he could be properly cared for at home, is that correct? One of the things that we have been concerned about is the minimum care at home. I regret to say that under the present program of the Government it is being reduced. The amount of funds available for home care is being reduced rather than increased. So one of the things that our Part C would provide is home care for those fortunate enough to have a home in bringing to the individual the skilled care, that is the doctors, the nurses and the other care like for instance the gentleman who is heavy and you needed someone to help move him about. If you had that kind of care along with the skilled care the individual could have been cared for in the home, is that correct?

Mrs. POPE. That is correct, and his care in the nursing home has always been from $2,400 a month to $2,000. They can take his Social Security. They do not want them though when they get where you do not have any money. They will kick them out. If you have had experience you would find that out.

Mr. PEPPER. It is our information that nursing home care now runs anywhere from $30,000 to $50,000 a year. You told us that when you had to pay these bills out of your diminishing income, that you were getting lower and lower in your ability to pay because what you have is being used up.

Mrs. BROYLES. Very fast.

Mr. PEPPER. That was all of your experience. We had a hearing in Washington before our committee where there were two sisters who testified about the care of their mother who had Alzheimer's They said our mother has been ill now for some 2 or 3 years or more. I remember very well one of the sisters said in 3 months my sister and I will have exhausted every penny we have to take care of our dear mother from this terrible disease. On the whole, we get the figure that about 4 million people a year, spouses, husbands and wives are being pauperized, just as you have had the money that you have expended in taking care of your loved ones. You had considerable assets.

Mrs. POPE. And we were glad to give it all.

Mr. PEPPER. One of our people had even less to begin with than you all had. So, as I said, the middle class is no longer safe. People that have good, normal dependable savings and own their home, can incur bills that require them to sell their home in order to make payments. So what we are talking about is these catastrophic cases where the cost is so great that the loving ones are just not able to bear it. Now when you come to the time when all your money is gone what are you going to do?

Mrs. POPE. That is it.

Mr. PEPPER. Now Medicaid will help take care of you when your assets are down to $1,500.

Mrs. BROYLES. Below $1,500.

Mr. PEPPER. I think Medicaid ordinarily will make you impoverish yourself so that you are bankrupt before they give you any help.

Mrs. BROYLES. And that includes insurance.

Mr. PEPPER. Everything is an asset. So the legislation that Ms. Lloyd and I are sponsoring would rechannel, for example, the money that the individuals have paid into Social Security for Medicare and then paid into Part B of Medicare. Unfortunately, the individual must then spend some more money to buy Medigap insurance trying to cover the deficiency of Medicare. What we are trying to do is let us take all the money being spent now through Medicaid, all the money being spent through Medicare, all the money spent by people who pay into Medicare in part B as well, channel that primarily through private administration and see if we cannot get more effective results without having to add any new costs to Medicare. We think one of the ways to do that is to provide for more home care so you do not have the rent on a building. People already have their own homes fortunately and can be treated there if they have proper personnel.

We are very much aware of what anguish you have been through meeting the present situation and we appreciate your being here today. Mrs. Lloyd.

Mrs. LLOYD. Thank you very much, Mr. Chairman. We are here today to focus in on this legislation. If you look at the the problems that we hope to eradicate and what is really needed to work up responsive legislation, I think that our three witnesses today come home with the answers, Chairman Pepper. And, we do see the need is here and the need is real and it is a need that touches every family.

You know, my father was extremely ill. He died about 20 years ago, Mr. Chairman, and he died the November before Medicare came into being with your legislation. My father was certainly not a wealthy man, he was a preacher, but he did the best of his ability to provide for his family. And yet we saw through my father's lingering illnesses and surgeries that wiped out all that my mother and dad had done and left my mother much in debt for the care that was provided him. And so for me, this was the beginning of seeing this need.

In addition to facing the financial burdens of care, Mrs. Broyles has the emotional strain of knowing there is no immediate answer for it. There is strictly at this time no answer for the extended coverage. There is no answer for Mrs. Pope's problems of providing the care that is needed at home and, Mr. Chairman, it would be so much more inexpensive, so much more efficient for the Federal Government to provide a program that would allow people such as Mr. Pope to remain at home to receive his care with his wife where he really wants to be.

And Ms. Wadel brought up the urgent need to take care of the gap that is not provided, the care that is given by our hospices that are doing such a wonderful job. I do hope that this hearing will illuminate the meaningful roles that the hospices are now playing in our society. They are doing an admirable job. We are very appreciative of them, but you know nothing is free and hospice cannot continue to absorb this type of expense.

Ms. Wadel, what would you estimate the number of cases that you have where there is no reimbursable cost?

Ms. WADEL. We average approximately 40 percent of our patient load. We do not receive any type of reimbursement.

Mrs. LLOYD. How long do you think that this can continue? This is an immediate need.

Ms. WADEL. It is an immediate need that we have right now.

Mrs. LLOYD. We have Mr. Bob Loflin here with us and he has done such a good job for our hospitals across the State pointing out that nothing is free. Our States have problems, our local government has problems and it is time that we focus in on a meaningful program. Let us not kid ourselves; this is an urgent need not only here but across the Nation of providing adequate, responsible care that would not only help people like Mrs. Broyles who is trying to take care of her husband and is every year having to sell more and more of everything she has, people like Mrs. Pope who wants her husband to be at home with her, and Ms. Wadel who is doing such a magnificent job of trying to care for people without the reimbursables. We hope that this program that we are trying to enact will address these concerns of people across our Nation. Thank you, Mr. Chairman.

Mr. PEPPER. May I just add this? As I say, we had another hearing over at the medical school named after my good friend Jim Quillen from Tennessee. We had a lot of our witnesses testify similarly to what you have testified today in Tennessee alone. Imagine how many other people there are who go through the same throes of agony and anguish that we have heard about from these three witnesses here today. Remember, Alzheimer's is the fourth largest killer in the United States today. Yet, it is not covered by the main

medical program we have to care for the people, especially the elderly. The elderly are the ones primarily the victims—most likely victims of this terrible disease, Alzheimer's disease.

As these witnesses have pointed out, all the evidence shows that symptoms began to appear, they get worse and worse and worse until you cannot leave the patient a minute but when he or she may hurt himself. Is that not true? It takes constant care, so the poor member of the family out of her love and care, tries to take care of the individual and they get to the point of exhaustion because of the demands that are made for that care. You can see just that one disease—and there are many others in a similar category that are similarly affected can have such a devastating financial impact. Thank you very much, Ms. Pope, Ms. Wadel, and Ms. Broyles for coming here and giving us your valuable testimony.

Mrs. POPE. Thank you, it was a privilege to come.

Mr. PEPPER. Our next panel consists of a number of witnesses. First is Mr. Doke Cage, administrator of the Hamilton County Nursing Home of Chattanooga. As I call the names of the ladies and gentlemen, would you please come forward and take your place at the table?

Mrs. LLOYD. I just met Dr. Young, who came up and spoke to my mother and me. He was one of the doctors who was so kind and good to my dad before he died, and I would like to acknowledge Dr. George Young.

Mr. PEPPER. Our next witness is Mr. Bob Loflin, senior vice president, Tennessee Hospital Association of Nashville. Next is Ms. Peggy Meier, director of Anderson County Office on Aging from Clinton, TN, and Ms. Rebecca Worley, a registered nurse, Superior Home Health Care Agency, Chattanooga, and Ms. Betty Leake, exdirector of the Home Visiting Nursing Services of Knoxville.

Mrs. LLOYD. Mr. Cage, Mr. Loflin, Ms. Meier, and Ms. Worley are all here. They are great people, too, I am awfully happy to have them here.

Mr. PEPPER. I know. We are delighted to have you. We appreciate your coming here today. We will begin with Mr. Doke Cage, administrator of the Hamilton County Nursing Home. Proceed, Mr. Cage.

PANEL TWO—THE CAREGIVERS: CONSISTING OF DOKE CAGE, ADMINISTRATOR, HAMILTON COUNTY NURSING HOME, CHATTANOOGA, TN; BOB LOFLIN, SENIOR VICE PRESIDENT, TENNESSEE HOSPITAL ASSOCIATION, NASHVILLE, TN; PEGGY MEIER, DIRECTOR, ANDERSON COUNTY OFFICE OF AGING, CLINTON, TN; REBECCA WORLEY, R.N., SUPERIOR HOME HEALTH CARE INC., CHATTANOOGA, TN; AND BETTY LEAKE, EXDIRECTOR, HOME VISITING NURSING SERVICE OF KNOXVILLE, TN

STATEMENT OF DOKE CAGE

Mr. CAGE. Mr. Chairman, Mrs. Lloyd, I am Doke Cage, administrator of Hamilton County Nursing Home. As a service provider for people with illnesses which are often financially devastating, I am grateful for this opportunity to share with you my concerns and experiences.

The Hamilton County Nursing Home provides a vertically integrated range of services, including adult day care, congregate care, residential or personal care, and skilled and intermediate nursing

home care. These services are concentrated on a single campus, which facilitates the steering of patients and residents to the situation most appropriate to their individual needs.

As we all know, medical advances have increased dramatically the average American life expectancy. Although serious illness can strike at any age, the elderly are more prone to such health problems than other segments of the population. As the majority of older Americans are living on fixed incomes, their financial outlay required to deal with illness often produces truly catastrophic results. Proud men and women who have worked hard all their lives and who value their independence find themselves destitute and totally dependent on the Government for the rest of their natural lives.

In many cases, families do their best to care for the ill and frail elderly in their home, but even with assistance from community-based services, they can become overburdened by the difficulty of the task. Alzheimer's disease is the classic example in which the spouse or other family member becomes the caregiver. The progression of this disease requires even greater time and effort on the part of the caregiver and not everyone can cope successfully with the demands made on them. Placement in a nursing home, with financial assistance from Medicare or Medicaid, is seen by the family as the only solution.

However, that financial assistance is not always there because the medical and/or financial eligibility criteria cannot be met. Cost to a spouse or a family for care of a nursing home resident in this area can approach $20,000 per year. But if the resident's needs can be met satisfactorily in a personal care setting, the cost can be considerably lower.

A range of services that include various levels of care for the elderly should be available within each health service area. Many, particularly those with fatal illnesses, require around-the-clock skilled nursing care while others may need only the degree of professional nursing provided at the intermediate care level. Some may need a very minimum of professional care but very intensive assistance with the activities of daily living. Some can avoid institutionalization altogether with services of adult day care. Others can continue a completely independent lifestyle with the services, the physical and emotional security provided within the congregate care setting. It is imperative these are available and assistance is provided in exercising these and other community-based options.

Public policy must address their availability, appropriate access, and methods of payment. Policy initiatives should have two goals: One, recognizing and acting on the need for increased services, and, two, encouraging family involvement in the caregiving process.

The private, nonprofit, and public sectors have to be encouraged to expand the service delivery capacity. Possible incentives for the private and nonprofit sectors are increased availability of small issue industrial development bonds and continuation of section 232 of the National Housing Act.

Within the public sector, there is a lack of an adequate national policy for the provision of reimbursement for services other than nursing home care. A revision of supplemental security income eligibility requirements is needed. For example, it is unfair and de-

meaning to be classified as an "inmate" and be denied benefits simply because one lives in a publicly operated residence of more than 16 persons.

To encourage family participation in caregiving, they must be given assistance in the identification and utilization of appropriate community-based services. Also, the current Medicaid eligibility and benefit requirements often encourage permanent institutionalization; they should be redesigned to provide an expanded respite care option.

The financial impact on elderly victims of illnesses and their families is already severe. It will worsen as Federal spending for social programs is reduced. Tax policies should acknowledge this serious problem and provisions adopted to lessen the financial burden. In some instances, this could encourage families to participate financially in the care of their elderly.

Mr. Chairman and Mrs. Lloyd, I wish to thank you for the privilege of addressing this body, and I share your concern for the problems of catastrophic illness and applaud your efforts to deal with the issue.

Mr. PEPPER. Thank you very much, Mr. Cage, for giving us your excellent statement. We will defer our questions until all the members of the panel have been heard.

Next is Mr. Bob Loflin, senior vice president, Tennessee Hospital Association. Mr. Loflin.

STATEMENT OF BOB LOFLIN

Mr. LOFLIN. Thank you, Mr. Chairman, Mrs. Lloyd. Personal privilege for a moment, I remember coming to Chattanooga 6 to 7 years ago again on behalf of Representative Lloyd when the Select Committee again met here earlier to do some improvements. I am privileged to be here again on the same issue, to help also with improvements and the Tennessee Hospital Association is privileged to be here on her behalf and yours.

Mrs. LLOYD. We appreciate all your good work.

Mr. LOFLIN. I am senior vice president for government relations for the Tennessee Hospital Association which represents the majority of all Tennessee hospitals and a variety of other health care organizations such as nursing homes. On behalf of our 165 institutional members, the hospital association welcomes this opportunity to testify before the Subcommittee on Health and Long-Term Care of this U.S. House Select Committee on Aging.

We are encouraged by your efforts to address the health care needs of our senior citizens in the current climate of cost consciousness and in the face of efforts to reduce the size of the Federal budget. The hospital association, however, believes that the pressing need to reduce Government spending should not be allowed to foreshadow or divert attention from other pressing issues. Therefore, we applaud the proposal by Dr. Otis Bowen, Secretary of Health and Human Services, to offer catastrophic benefits for senior citizens under a reformed Medicare system and for your proposal to make the necessary changes.

A significant number of Medicare beneficiaries have a very real problem in affording catastrophic illness expenses despite consider-

able progress made over the past 20 years. It has been reported that only 2 percent of Medicare patients ever exhaust their acute inpatient hospital benefits. Far more pressing needs arise for services that are not covered by current Medicare benefits; many types of extended care, care for the chronically ill, and outpatient pharmaceuticals. The need for such coverage is all the more important today as we seek and develop new alternatives to treatment in the inpatient setting. Reforms need to be developed with a sensitivity to the variations in the needs and resources of Medicare beneficiaries themselves.

While Secretary Bowen's proposal has not yet been officially released, the American Hospital Association has identified some of the issues that must be addressed by any catastrophic program based on what Dr. Bowen has stated unofficially.

First, we must clearly define what is meant by catastrophic protection. It is important to begin thinking about catastrophic protection in new terms that fit new and emerging financing and delivery systems. Simply expanding the coverage of acute inpatient services will do little to address the problem of catastrophic illness. Innovative benefit designs are needed to respond to the new patterns of utilization and to the needs of those beneficiaries most likely to experience catastrophic illnesses; including the chronically ill, those in need of rehabilitation, and beneficiaries in the last years of their lives. In designing such a program, it is important to recognize that the growing reliance of noninpatient services simply means that less expensive services may be substituted for more expensive services.

Second, if a catastrophic benefit is to be provided by Medicare, it is important to reassess how well the needs of the elderly are currently being met by both Medicare and Medicaid. Medicaid has become largely a program of supplemental insurance for patients receiving benefits under Medicare. The patchwork of benefits under Medicare and Medicaid provides incomplete and uncertain protection and does not necessarily encourage the development of less costly and more effective methods to meet the needs of beneficiaries with catastrophic or chronic illness.

Many elderly have limited income and assets, but still have sufficient medical needs. Among the most important of these needs is coverage for postacute extended care. Another important area is the adequacy of coverage for acute treatment in nonpatient settings. You heard about both of these this morning. These services will, over time, account for an increasing part of the burden carried by the elderly unless benefit design is re-examined. An essential part of these reforms is the ongoing effort to encourage the cost-effective use of all medical services.

We in Tennessee are particularly concerned about health care for the poor, the working poor, the poor elderly and those with inadequate or no private health insurance. Our State has a very limited Medicaid program covering only 36 percent of the State's poverty population in 1984.

Currently with leadership from Chattanooga State Representative Paul Starnes, our legislature is attempting to improve our Medicaid Program. However, the issue of indigent care is not just a State issue, it is a national problem which is complicated by reim-

bursement reductions for both Medicare and Medicaid now compounded by the Gramm-Rudman-Hollings law.

The ability of hospitals to cope with tighter and tighter budgets is being strained to the limit. The safety net for our senior citizens and for those who are poor is in tatters. The number of our elderly are exploding, not shrinking, and the number of the indigent is increasing. The unofficial and unfair system of cost shifting that robs insured Peter to pay for uninsured Paul is coming to an end. Therefore, there must now be recognition and action at both the National and State Government levels of the needs and means to assume the responsibility for reform of health benefit programs for the elderly and for the poor.

Congressman Pepper, Congresswoman Lloyd, we appreciate you allowing us to present this statement today. We have a much more detailed statement that we have offered to you in writing. We will be happy to answer any questions that you have and furnish further information to you and other Members of Congress as you continue to look into this problem. Thank you.

[The prepared statement of Mr. Loflin follows:]

PREPARED STATEMENT OF BOB LOFLIN, SENIOR VICE PRESIDENT FOR GOVERNMENT RELATIONS, TENNESSEE HOSPITAL ASSOCIATION, NASHVILLE, TN

SUMMARY STATEMENT

Catastrophic health care expenses are a real and growing problem for Medicare beneficiaries, but these expenses are usually incurred for types of medical care other than acute inpatient care. Although the inpatient deductible has risen sharply over the past five years, out-of-pocket expenses for hospital care are only a fraction of out-of-pocket expenses for other types of medical care. It has been reported that only 2 percent of Medicare patients ever exhaust their acute inpatient hospital benefits.

Medicare is primarily a benefit program for acute hospital inpatient care and only to a lesser degree does it cover other forms of health care delivery. The inpatient deductible, rather than any limitation on benefits, makes up the majority of out-of-pocket expenditures by Medicare beneficiaries for inpatient hospital care. In other areas, especially extended care, out-of-pocket expenditures by Medicare beneficiaries are much higher due to less comprehensive coverage or no coverage of services by Medicare. Protection for the elderly from the expenses of catastrophic illness is a needed reform of the Medicare system. The scope of the problem must be identified and defined. Then a system of benefits can be designed to deliver less costly and more effective care to those with catastrophic or chronic illnesses with particular attention paid to acute care in non-inpatient settings and to post-acute extended care.

INTRODUCTION

Mr. Chairman, I am Bob Loflin, Senior Vice President for Government Relations of the Tennessee Hospital Association (THA), which represents the majority of all Tennessee hospitals and a variety of other healthcare organizations, such as nursing homes. On behalf of our 165 institutional members, the THA welcomes this opportunity to testify before the Subcommittee on Health and Long-Term Care of the U.S. House Select Committee on Aging.

We are encouraged by your efforts to address the health care needs of our senior citizens in the current climate of cost consciousness and in the face of efforts to reduce the size of the federal budget. The THA, however, believes that the pressing need to reduce government spending should not be allowed to overshadow or divert attention from other pressing issues. Therefore, we applaud the proposal by HHS Secretary Otis Bowen, M.D., to offer catastrophic benefits for senior citizens under a reformed Medicare system. Today's hearing, plus recent statements by Secretary Bowen, are clear evidence of the need to reassess the adequacy of the general design of the Medicare program. This is very important in light of changes in the financing and delivery of medical care and the need to respond to the changing needs of Medicare beneficiaries themselves.

A significant number of Medicare beneficiaries have a very real problem in affording catastrophic illness expenses despite considerable progress made over the past 20 years. However, the problem is rarely a result of inpatient hospital and medical care. Out-of-pocket expenses for hospital care are only a fraction of out-of-pocket expenses for other types of medical care although the inpatient deductible has risen sharply over the past five years. It has been reported that only 2 percent of Medicare patients ever exhaust their

acute inpatient hospital benefits. Far more pressing needs arise from services that are not covered by current Medicare benefits: many types of extended care, care for the chronically ill, and outpatient pharmaceuticals. The need for such coverage is all the more important today as we seek and develop new alternatives to treatment in the inpatient setting. These developments highlight the importance of continuing and completing the reforms begun with the adoption of prospective pricing under Medicare for acute inpatient hospital services. One element of the needed reforms is catastrophic protection, particularly if combined with the development and implementation of new delivery and financing mechanisms. Such reforms, however, need to be developed with a sensitivity to the variations in the needs and resources of Medicare beneficiaries.

STATISTICAL PROFILE

In testimony before the House Ways and Means Committee Subcommittee on Health last month, the American Hospital Association provided some useful statistics in regard to Medicare benefits and the need for catastrophic benefits. We share that information with you.

The most recent data on personal health care expenditures on behalf of the elderly indicate that out-of-pocket expenditures declined in importance as a source of funding between 1977 and 1984. In 1977, out-of-pocket personal health care expenditures by the elderly accounted for 29 percent of the total, but by 1984 these expenses accounted for just over 25 percent of the total. Although falling in relative terms, in absolute dollars out-of-pocket expenditures per person did increase--doubling from $522 in 1977 to $1,059 in 1984. However, these figures are averages and reflect the combined experience of those who used no medical services and those who experienced a catastrophic illness. Although estimates of out-of-pocket expenditures by those who used medical services are not available, approximately one-third of all Medicare beneficiaries use no services over the course of a year. Therefore, it is clearly possible that out-of-pocket expenditures are actually much higher than the overall average suggests.

Medicare is, not surprisingly, the most significant source of funding for the medical care received by the elderly, accounting for 49 percent of the total personal health expenditures on behalf of the elderly in 1984. However, Medicare is primarily a program of benefits for acute inpatient care. In 1984, Medicare paid for 75 percent of acute hospital care and 58 percent of physician services, which includes home health care and drugs consumed outside of inpatient settings. If home care services were excluded from the last category, the percentage of total expenditures accounted for by Medicare would be extremely low because Medicare provides no coverage for outpatient drugs and limited coverage for the remaining services in the category. Over 80 percent of drug expenditures, and over 95 percent of dental expenditures are derived from private sources.

These statistics highlight the different origins of out-of-pocket expenditures by Medicare beneficiaries. Although benefit limitations and copayments are one source of out-of-pocket expenditures, they are not the most important source. The acute inpatient deductible is largely responsible for out-of-pocket expenditures for hospital care. A much less important source is the limitations on inpatient benefits. Exact figures are not available, but, reportedly, a very small percentage of Medicare patients ever exhaust their inpatient coverage. In other areas, such as extended care, the limitations on benefits are a major factor. And in the area of "other" services, the complete absence of coverage is the principal cause of out-of-pocket expenditures.

Coverage for outpatient services other than home health care is restricted to those beneficiaries participating in Medicare Part B. Although nearly all Medicare beneficiaries participate in Part B, a few do not and are not eligible for Medicaid. As Medicare adopts policies to shift utilization from inpatient to outpatient settings, Medicare will cover a declining percentage of total expenditures for the elderly because coverage of these settings is less generous than coverage for acute inpatient services. To some degree, the adoption of these policies saves money for the federal government simply by shifting services from covered to non-covered settings and shifting costs from the Medicare program to its beneficiaries.

Further statistics from the American Hospital Association are included as attachments to our testimony. It should be noted that the population over age 65 doubled between 1950 and 1980 and is expected to double again by the year 2030. The age group over 85 is growing 3-4 times as fast as the general population. With age comes increased use of services, especially associated with chronic illness, as contrasted to acute episodic illness or injury.

CONCLUSIONS

Secretary Bowen's proposal has not yet been released and we are not able to comment on its provisions. Prior to his appointment as HHS Secretary, Dr. Bowen outlined his ideas in an article he co-authored for the December, 1985, issue of Review, the magazine of the Federation of American Hospitals. He stated, and I quote, "The proposal is intended to be provocative. The acid test of any idea is whether it will stand up to the close scrutiny of other professionals in the field. It is being presented with that objective in mind. If it does weather the close examination of others, perhaps it then would be given careful consideration by our nation's policymakers."

We agree and hospitals want to be full participants in that debate. Already, we are able to identify some of the critical issues that must be addressed by any catastrophic benefit program.

First, we must clearly define what is meant by "catastrophic protection." It is important to begin thinking about catastrophic protection in new terms that fit new and emerging financing and delivery systems. Simply expanding the coverage of acute inpatient services will do little to address the problem of catastrophic illness for Medicare beneficiaries. Innovative benefit designs are needed to respond to the new patterns of utilization and to the needs of those beneficiaries most likely to experience catastrophic illnesses: the chronically ill, those in need of rehabilitation, and beneficiaries in the last years of their lives. In designing such a program, it is important to recognize that the growing reliance on non-inpatient services simply means that less expensive services may be substituted for more expensive services, not that meeting the needs of the elderly will be inexpensive.

Second, if a catastrophic benefit is to be provided by Medicare, it is important to reassess how well the needs of the elderly are currently met by both Medicare and Medicaid. Medicaid has become largely a program of supplemental insurance for patients receiving benefits under Medicare. Nearly three quarters of Medicaid's annual expenditures go to pay for supplemental Part B Medicare coverage, outpatient services not covered by either Part A or Part B of Medicare, or long term care for Medicare beneficiaries who have exhausted their private resources. Aside from leaving few resources to address the needs of the medically indigent who are not entitled to benefits under Medicare, the reliance on Medicaid to provide "catastrophic" protection for Medicare beneficiaries may be neither efficient nor equitable. In particular, the patchwork of benefits under Medicare and Medicaid provides incomplete and

uncertain protection and does not necessarily encourage the development of less costly and more effective methods to meet the needs of beneficiaries with catastrophic or chronic illness.

Medicaid eligibility criteria completely exclude many of the elderly who have limited income and assets, but still have sufficient medical needs. Among the most important of these needs is coverage for post-acute extended care. Another important area is the adequacy of coverage for acute treatment in non-inpatient settings. These services will, over time, account for an increasing part of the burden carried by the elderly unless benefit design is reexamined. The adoption of less comprehensive measures will serve to ameliorate out-of-pocket expenses for some, but will leave the underlying problem largely untouched. The adoption of such measures should be based on a commitment to make the kinds of changes in the design of the Medicare program that will enable the program to remain strong over the long term. An essential part of these reforms is the ongoing effort to encourage the cost-effective use of medical services.

We in Tennessee are particularly concerned about health care for the poor, the working poor, the poor elderly and those with inadequate or no private health insurance. Our state has one of the most limited and most restrictive Medicaid programs of any state in the Union. Although Tennessee has a large portion of its population falling below the federal poverty level, Medicaid covered only 36 percent of the state's poverty population in 1984.

Currently, our state legislature, with leadership from Chattanooga state representative Paul Starnes, is attempting to improve our Medicaid program. However, our efforts are being threatened by proposals to slash and then freeze funding for state Medicaid programs. The Reagan Administration's proposal to reduce federal Medicaid funding by $1.2 billion in the next fiscal budget will seriously jeopardize our efforts and those of other states to finance indigent health care The issue of indigent care is not just a state issue; it is a national problem.

The issue is further complicated by reimbursements under the Medicare prospective payment system. Although Congress made a commitment to maintain prospective payment rates that are fair, equitable and which give providers incentives to provide cost-effective care without sacrificing quality, the Gramm-Rudman-Hollings law seriously jeopardizes that commitment. Since Congress has not been able to enact a 1986 budget, Gramm-Rudman-Hollings has already reduced Medicare DRG rates to one percent below rates paid in 1985. This has come despite substantial cost containment results that have slowed the annual growth in hospital expenditures to the lowest rate in two decades.

The federal government has cut $35 billion from Medicare in the past five years. Moreover, Gramm-Rudman-Hollings will reduce Medicare funding by two percent each year through 1990. Congressman Henry Waxman has called the Gramm-Rudman-Hollings law "the greatest threat to health in this country that has ever passed Congress." We share Mr. Waxman's concern that, if budget reductions continue, hospitals will be forced to cut back on the quality and amount of care they can afford to provide to Medicare beneficiaries--let alone the poor and uninsured.

The ability of hospitals to cope with tighter and tighter budgets is being strained to the limit. The "safety net" for our senior citizens and for those who are poor or do not qualify for Medicaid is in tatters. The number of our elderly are exploding, not shrinking. The number of the indigent are increasing at unprecedented rates.

In 1984, Tennessee hospitals absorbed $371,708,050 in Medicare adjustments, $61,943,098 in Medicaid adjustments, $124,816,810 in direct charity and $201,124,916 in bad debt charges caused largely by medical indigency. The combined total of unreimbursed or under-reimbursed charges totaled $749,592,872, an 82.84 percent increase since 1981.

Traditionally, hospitals have been able to absorb these revenue shortfalls with profits from private patients. However, the base of private patients is being rapidly eroded through efficiency that is reducing hospital admissions and lengths of stay, by alternative delivery and financing systems and by the growing reluctance of private payors to pay higher rates to subsidize patients who cannot pay for their care. The unofficial and unfair system of cost shifting that robs insured Peter to pay for uninsured Paul is coming to an end. Fifty-three Tennessee community hospitals in 1984 took in less money from patient care than they spent in providing that care. Thirty of these hospitals were in one hospital communities and 33 of these hospitals had patient revenue shortfalls during three consecutive years. These hospitals have survived by dipping into their reserved funds.

We do not advocate propping up unprofitable hospitals that are not competitive but we oppose a system that will allow a hospital to become bankrupt because under-reimbursments and the lack of benefits for indigent patients tip the balance toward insolvency. Small hospitals and those in rural areas are particularly vulnerable.

We support adjustments and refinements in the Medicare prospective payment system to help address some of these problems. We particularly support changes in the area wage index, allowances to hospitals with disproportionate shares of low income and elderly patients, allowances for the higher costs associated with teaching hospitals and the adoption of the "swing bed" concept that would allow many hospitals to adjust the use of inpatient beds to the needs of their patients.

Congressman Pepper, Congresswoman Lloyd and other distinguished members of the Subcommittee, we appre iate your allowing us to present this statement today. We will be happy to answer any questions that you may have and to furnish further information to you and other members of Congress as you continue your deliberations. Thank you.

ATTACHMENT
PERSONAL HEALTH CARE EXPENDITURES FOR THE ELDERLY

The over-65 population doubled between 1950 and 1980 and will double again by the year 2030. The over-85 group is growing fastest--3-4 times as fast as the general population. With age comes increased use of services and increasing association with chronic illness as contrasted to acute episodic illness or injuries.

Catastrophic need among those 65 and over is likely to come from chronic illness and from services not covered by Medicare. Consequently, removing quantity limits on already covered services is unlikely to provide protection against catastrophic medical expenses.

In 1984, personal health expenditures for the 65 and over group were $119.9 billion with:

48.8% covered by Medicare
25.2% paid out of pocket
12.8% covered by Medicaid
7.2% covered by private insurance
5.6% covered by other government programs

Closer examination of the expense category breakdowns points to where the elderly are most vulnerable. Hospital, physician, and nursing home care combine to account for 86.8% of total expenditures, but there is wide variation among the three categories in terms of payment source:

- 74.8% of hospital care (which is 45.2% of total expenditures) is covered by Medicare, with private insurance covering 7.9% and the patient paying only 3.1% out of pocket.
- Only 2.1% of nursing home care (the second largest category, accounting for 20.9% of total expenditures) is covered by Medicare. Patients directly fund 50.1%, while private insurance pays 1.1% and Medicaid picks up 41.5% Patients have to become impoverished to receive help with nursing home care.
- 57.8% of physician care (20.7% of total expenditures) is covered by Medicare, with private insurance covering 13.5% and patients themselves funding 26.1%.

In 1984, the elderly spent 15% of their annual income for health insurance and out-of-pocket health care expenses. Out-of-pocket health care expenses averaged $1,059 in 1984, up from $522 in 1979. Acute care and other categories of service currently covered by Medicare accounted for very little of this. On average, the $1,059 breaks down as follows:

$59 (5.6%) for hospital care
$227 (21.4%) for physician services
$441 (41.6%) for nursing home care
$332 (31.3%) for drugs, eyeglasses, dental care and other services.

TABLE 1
SOURCES OF PAYMENT FOR PERSONAL HEALTH EXPENDITURES BY THE ELDERLY

	1977 TOTAL CARE	1984 TOTAL CARE	PERCENT CHANGE 1977-84
TOTAL EXPENDITURES	$43,423	$119,872	176%
Out-of-pocket	$12,706	$30,198	138%
Private Insurance	$2,792	$8,677	211%
Other Private	$170	$466	174%
Medicare	$19,171	$58,519	205%
Medicaid	$6,049	$15,288	153%
Other Gov't.	$2,535	$6,724	165%
PERCENT DISTRIBUTION			
Out-of-pocket	29.3%	25.2%	
Private Insurance	6.4%	7.2%	
Other Private	0.4%	0.4%	
Medicare	44.1%	48.8%	
Medicaid	13.9%	12.8%	
Other Gov't. 5.8%	5.6%		

PER CAPITA EXPEND	$1,787	$4,206	135%
Out-of-pocket	$523	$1,060	103%
Private Insurance	$115	$304	165%
Other Private	$7	$16	134%
Medicare	$789	$2,053	160%
Medicaid	$249	$536	115%
Other Gov't.	$104	$236	126%

SOURCE: Office of Financial and Actuarial Analysis Health Care Financing Administration

Data taken from Daniel R. Waldo and Helen C. Lazenby, Demographic characteristics and health care use and expenditures by the aged in the United States: 1977-84, Health Care Financing Review 6:1:1-29 (Fall 1984)

TABLE 2
DISTRIBUTION OF PERSONAL HEALTH EXPENDITURES
BY TYPE OF CARE AND SOURCE OF PAYMENT: 1977

	1977 HOSPITAL	1977 PHYSICIAN	1977 NURSING HOME	1977 OTHER CARE
TOTAL EXPENDITURES	$18,906	$7,781	$10,695	$6,041
Out-of-pocket	$927	$2,147	$5,264	$4,368
Private Insurance	$1,336	$1,173	$88	$195
Other Private	$56	$3	$72	$39
Medicare	$14,087	$4,158	$348	$578
Medicaid	$733	$232	$4,453	$631
Other Gov't.	$1,767	$68	$470	$230
PERCENT DISTRIBUTION				
Out-of-pocket	4.9%	27.6%	49.2%	72.3%
Private Insurance	7.1%	15.1%	0.8%	3.2%
Other Private	0.3%	.0%	0.7%	0.6%
Medicare	74.5%	53.4%	3.3%	9.6%
Medicaid	3.9%	3.0%	41.6%	10.4%
Other Gov't.	9.3%	0.9%	4.4%	3.8%
PER CAPITA EXPEND	$778	$320	$440	$249
Out-of-pocket	$38	$88	$217	$180
Private Insurance	$55	$48	$4	$8
Other Private	$2	$0	$3	$2
Medicare	$580	$171	$14	$24
Medicaid	$30	$10	$183	$26
Other Gov't.	$73	$3	$19	$9

SOURCE: Office of Financial and Actuarial Analysis Health Care Financing Administration

Data taken from Daniel R. Waldo and Helen C. Lazenby, Demographic characteristics and health care use and expenditures by the aged in the United States: 1977-84, Health Care Financing Review 6:1:1-29 (Fall 1984)

TABLE 3
DISTRIBUTION OF PERSONAL HEALTH EXPENDITURES
BY TYPE OF CARE AND SOURCE OF PAYMENT: 1984

	1984 HOSPITAL	1984 PHYSICIAN	1984 NURSING HOME	1984 OTHER CARE
TOTAL EXPENDITURES	$54,199	$24,770	$25,105	$15,798
Out-of-pocket	$1,694	$6,468	$12,569	$9,467
Private Insurance	$4,270	$3,350	$287	$770
Other Private	$196	$9	$182	$79
Medicare	$40,524	$14,314	$539	$3,142
Medicaid	$2,595	$467	$10,418	$1,808
Other Gov't.	$4,920	$162	$1,110	$532

PERCENT DISTRIBUTION				
Out-of-pocket	3.1%	26.1%	50.1%	59.9%
Private Insurance	7.9%	13.5%	1.1%	4.9%
Other Private	0.4%	.0%	0.7%	0.5%
Medicare	74.8%	57.8%	2.1%	19.9%
Medicaid	4.8%	1.9%	41.5%	11.4%
Other Gov't.	9.1%	0.7%	4.4%	3.4%
PER CAPITA EXPEND	$1,902	$869	$881	$554
Out-of-pocket	$59	$227	$441	$332
Private Insurance	$150	$118	$10	$27
Other Private	$7	$0	$6	$3
Medicare	$1,422	$502	$19	$110
Medicaid	$91	$16	$366	$63
Other Gov't.	$173	$6	$39	$19

SOURCE: Office of Financial and Actuarial Analysis Health Care Financing Administration

Data taken from Daniel R. Waldo and Helen C. Lazenby, Demographic characteristics and health care use and expenditures by the aged in the United States: 1977-84, Health Care Financing Review 6:1:1-29 (Fall 1984)

TABLE 4
PERCENT CHANGE IN PERSONAL HEALTH EXPENDITURES
BY TYPE OF CARE AND SOURCE OF PAYMENT: 1977-1984

	PERCENT CHANGE: 1977 to 1984			
	HOSPITAL	PHYSICIAN	NURSING HOME	OTHER CARE
TOTAL EXPENDITURES	187%	218%	135%	162%
Out-of-pocket	83%	201%	139%	117%
Private Insurance	220%	186%	226%	295%
Other Private	250%	200%	153%	103%
Medicare	188%	244%	55%	444%
Medicaid	254%	101%	134%	187%
Other Gov't.	178%	138%	136%	131%
PER CAPITA EXPEND	144%	171%	100%	123%
Out-of-pocket	56%	157%	104%	85%
Private Insurance	173%	144%	178%	237%
Other Private	198%	156%	116%	73%
Medicare	145%	194%	32%	363%
Medicaid	202%	72%	99%	144%
Other Gov't.	137%	103%	101%	97%

SOURCE: Office of Financial and Actuarial Analysis Health Care Financing Administration

Data taken from Daniel R. Waldo and Helen C. Lazenby, Demographic characteristics and health care use and expenditures by the aged in the United States: 1977-84, Health Care Financing Review 6:1:1-29 (Fall 1984)

Mrs. LLOYD. Thank you very much.

Mr. PEPPER. We thank you, Mr. Loflin, for a very excellent and a very able statement. We will have some questions in a moment.

Next is Peggy Meier, director of the Anderson County Office on the Aging. Ms. Meier, we are pleased to have you.

STATEMENT OF PEGGY MEIER

Ms. MEIER. Thank you. I want to thank you for inviting me here this morning. I am coming from a little different direction than the two gentlemen who have preceded me.

I am the director of the Office on Aging in my county and our funding is provided by the Older Americans Act. It is my job to try to pull the resources in our county together for the elderly. I am a little frustrated right now because already, beginning on March 1st, we had to make a 4.3-percent cut in our budget, and our budget is not very large; and so I am beginning to see the support of services that we have worked for over 10 years, 12 years I believe in our county, begin to be whittled away a little at a time, and I am afraid the next cut is going to be a more major cut.

As I see it, the key to providing assistance to the semi-independent individual—elderly individual is community services. Meals delivered to the home-bound elderly, home-health care, transportation for those who are no longer able to drive themselves to the doctor, the grocery store or the bank or shopping trips that are necessary to remaining independent. As I took a look back and analyzed the cases that brought the above points home, I find some missing services in our community and I am distressed over this. An adult day care center would provide a program for the individual who needs daily assistance but has someone at home in the evening to help provide the care for them. We have none in our county.

California has found, for example, that an Alzheimer victim who spends his days or her days in day care center delays departure for the nursing home by 20 months and they find that either by paying for this adult day care center through Medicaid funds that they save the difference between the adult day care center and the nursing home is $3,600 a year per patient. Our State does not fund day care centers or day care programs and perhaps we need some direction from the Federal Government on this level.

Another way to encourage the family to provide care would be to have respite care programs available. As a patient, I found it necessary to send my three active children to summer camp every year to get a relief from them and them to get a relief from me, and I feel that when one is providing 36 hours a day care that they do need some rest and respite and we do not have respite care programs readily available.

Home health care programs are limited in the number of visits covered by Medicaid; 60 visits a year. Medicaid pays for an average of 3 weeks' service after a hospitalization period and at the moment—I was glad to hear the chairman mention that we did not have coverage for eye glasses and hearing aids and dental care. I have 16 people on a waiting list whose incomes are not over $400 a month that need assistance in buying eye glasses or dentures and I

tell you I consider good teeth or the ability to use my teeth very important and my eye glasses very important and these people are waiting for me to raise funds outside of the Federal funding that I have so that they can get the help they need.

Recently, the whole issue was brought home to us. My husband's 95-year-old aunt died the 10th of this month. She had worked for over 50 years in a small firm in a community of 12,000 people in Michigan and we found that she could not manage her day-to-day life any longer. So the family had to place her in a nursing home and we were fortunate because she had the resources necessary to pay for this. The cost there was $19,000 a year for intermediate care. She fell the first of the month and broke her pelvic bone and 10 days later she had died. She wanted to live at home. Every time we went to see her, she pleaded with my husband, who was her favorite nephew, to take her home. We could not take her home. We had to leave her there, and it was difficult and we felt that we let her down.

Mr. PEPPER. May I interrupt you just a minute?

Ms. MEIER. Yes.

Mr. PEPPER. I never shall forget the number of times that my own dear mother told me before she finally passed away, son, do not ever let them put me in one of those nursing homes. She did not intend to disparage the nursing home. They are necessary for certain people. There are a few bad ones, I am sure, but most of them are good. But, she knew what her home was like. She had her flowers that she nurtured and planted, her neighbors round about. She did not have to keep anybody's timetable, anybody telling her when to eat or when to go to bed and when to get up. When her children wanted to come to see her, they could come at her pleasure. So fortunately, she never had to go in a nursing home. She lived until the night she passed away in her own home. Well, you bring back those tender memories to me when you say your husband's aunt did not want to go to a nursing home, she wanted to stay in her own home. Go ahead.

Ms. MEIER. Since we live 500, 600 miles away, we really did not feel we had a choice.

Recently, one of the nicest people I have—that I have worked with in the 3 years I have been in this job, she too was 95, and last August she fell and broke her hip picking up a piece of paper in her driveway. She was moved to a nursing home from the hospital to receive therapy. As long as she was on Medicare she was retained at that nursing home, but when her Medicare ran out and her private insurance ran out, Medicaid was about to take over, it was necessary for her family to move her to another nursing home. This meant another adjustment and it was difficult for her. In December, I went to see her and in fact I took her out to a Christmas party in the nursing home. She talked to me about returning home to her home in the spring. In January she—someone from my office went to see her and she had given up and she died a short time later because she had realized that she could not go home, and her dream was to finish out her life at home, and this was denied many. Again, I can see that if there had been some help programs available, we could have kept her home.

One of the things our budget does is help support a nonprofit home health care agency and the type of individual they take care of is poor, frail and usually alone older persons. One client they see has been a patient for several years and they see her 7 days a week at a cost of $7,300 per year. A nursing home would cost a minimum and I—my figure was $14—this is the basic figure $1,400—$14,000 a year. They spend 2½ hours a day providing personal care; baths, light housekeeping, meal preparation and laundry for this woman, and they are helping to keep her at home and she is one of several.

They brought me a list—a representative list of their clients when they found I was going to come down here and several, we decided, would have to be placed in nursing homes on Medicaid without their service. This is a nonprofit organization, and they are doing a fantastic job, as most of the home health care agencies that I have dealt with are doing. Two of their clients are recent widows and they now need additional care that their husbands had been receiving. One is an Alzheimer's victim, and she is seen three times a week for 4 hours each time. An adult day care program might provide the additional care needed to maintain her at home a little longer and, incidentally, save all of us some money.

Another tragic case is the woman in her late eighties with a trust fund that has dwindled to $8,000. This trust is rapidly being expended for her care and prevents her from receiving any Goverr-ment aid. Her Social Security is $250 a month. She is receiving home health care several times a week again through this nonprof-it agency. I think we can all see that it is only going to be a short time before she, too, will be receiving assistance.

Three other victims—three other patients are long-term patients. One is a stroke victim and has been a patient for 7 years. One is about my age, and I do not quite meet the age requirement for the Older Americans Act yet, suffers from a disease that paralyzed her lower extremities about 20 years ago. Today she is alone and very depressed over her future. She is also a friend of mine and I have known her for a long time. Another is over 80, blind, has osteoporo-sis and is diabetic and alone. These are their patients.

All of these people need long-term care, community based long-term care. With some assistance and it varies from case to case, they can manage to remain at home a little longer. I see a need for quality home health care programs, adult day care programs, more home delivered meals, not less as we have had to cut the first of this month, more local transportation programs, and I would like to see some new programs, innovative programs that we have not even begun to think about at the time. The group of people over 75 who came through the Depression are my parents' ages, and they look at nursing homes as something for poor folks. They fight to stay out of the nursing home, and they deserve to have their wishes fulfilled and to keep their dignity.

Those of us who deliver the social services and see the anguish on a very personal basis would like to see more community pro-grams providing the necessary assistance to keep our elderly at home, where they belong.

Thank you for your time and interest. If you have any questions, I will be glad to try and answer them.

Mr. PEPPER. Thank you very much, Ms. Meier.

Ms. MEIER. Thank you very much.

Mr. PEPPER. Now the next witness will be Ms. Rebecca Worley. She is a registered nurse from the Superior Home Health Care Agency from Chattanooga. Ms. Worley, we will be pleased to hear from you.

STATEMENT OF REBECCA WORLEY

Ms. WORLEY. Thank you. Good morning, Congressman Lloyd, Congressman Pepper, and distinguished guests.

As a provider of home health for the past 6 years, I have witnessed many sad and frustrating situations of patients who are faced with catastrophic illnesses. Many of these situations could be made less devastating if there was a more comprehensive coverage for these unfortunate victims. The need for better coverage for those faced with catastrophic accidents and illnesses can be pointed out by identifying the many inadequacies and problems with our current coverage benefits.

But first, let us address the problem of patients who are in need but do not yet qualify for either of these programs and who may have little, if any, other coverage. Like the case of Mr. B, a 58-year-old heart attack victim. His attack was so severe he was sent home on continuous oxygen, multiple and expensive medications, and primarily bed to chair bound. He did not qualify for Medicare because he was too young and had not been totaly disabled for the 2 years required in order to qualify if you are not already on Social Security. He did not qualify initially for Medicaid and could not qualify for 3 months after his hospital stay when his financial resources had finally almost been totally exhausted. He was single, lived alone, totally and permanently disabled and for several months he had no coverage for his much needed care.

Patients who have Medicare and Medicaid are in better situations, but far too many of these patients suffer the inadequacies of our benefits. One of the major problems is the visit limitations placed on home health agencies. Tennessee Medicaid will allow only 60 visits per year per patient, and when these visits are exhausted no more will be granted under any circumstances. That is hardly more than 1 visit per week. In order to qualify for benefits under Medicare, the patient must require skilled services on an "Intermittent" basis only. This means that victims cannot be seen on a daily basis for more than a 2- to 3-week period. This definition of intermittent care has especially been a problem since the implementation of DRG's. Patients are being sent home from the hospital in more acute phases of illness and there has been no expansion of our services in order to provide the additional care so badly needed. We have experienced many problems in this area, such as patients needing intramuscular or intravenous antibiotics two to three times a day, or on a daily basis for up to 6 weeks. Another example is the patient with large, open, draining wounds that require complicated sterile dressing procedures on a twice daily basis initially and later on a daily basis for an extended period of time. In many instances there is no one in the home who can be taught the complicated dressing procedures, or the home environment or

wound condition is such that it would be unwise to leave this task for a family member to do.

Other problems result due to lack of coverage for preventive or maintenance care. Under Medicare, a patient can have the services of home health aides only if he also requires the skilled services such as nursing or physical therapy. When this skill is no longer required, the home health aide services must be stopped as well, but many times the patient's need for assistance in meeting their personal hygiene and activities of daily living does not stop here. This frequently occurs with patient's suffering from chronic lung conditions, Parkinsonism, strokes, and arthritis. Ironically, we can treat the bedsores and painfully contracted extremities for these patients once these inflictions have developed, but we cannot provide any services that would be preventive in nature or would solely maintain them in the home.

Similarly, the lack of coverage for any sitters or private duty nurses, even on an occasional or intermittent basis, that would allow family members a much needed respite from the burden of the 24- hour-a-day, 7-day-a-week job. Too often we see families resort to nursing home placement after total emotional and phypsical exhaustion when many of these families would have opted for home care and keeping their loved ones at home if only more supportive services could have been obtained.

There are other gaps in current benefits, such as the lack of coverage for ambulance transportation costs for outpaitnet or doctors' office visits. Most of these ambulance trips are in excess of $100 round trip. The irony of this is that in order to qualify for home health care benefits, the patient must see his physician at least once every 60 days with few exceptions. So, if the patient requires and cannot afford this expensive ambulance transportation, they may stand to lose their home health care as well.

Congressman Pepper, you have already addressed the situation of the expense of medications which Medicare does not provide. Medicaid will pay for some approved medications, but again the coverage is limited.

The problem areas I have mentioned so far are ones that have been frustrating situations for those of us in home health care for a long time past, but now there are new problems on the horizon and if these are not addressed our industry today may well be closing down the provision of care and agencies in many areas.

In addition to lower reimbursement rates per visit this year, with a further decrease in reimbursement scheduled for next year, we must now be cost effective by discipline. Without a long explanation, let me just say that this will not be possible for some agencies and the result may well be a decrease in the provision of some very needed services such as physical therapy, speech therapy and social work. Some of these disciplines are especially hard to obtain and provide in rural areas of our State where we have to relocate those professionals. Also, we have recently learned that thanks to Gramm-Rudman, we will be reimbursed 1 percent less by our fiscal intermediaries. Since home health agencies are reimbursed on a basis of operating costs, no matter how frugally an agency operates, it will only recover 99 percent of its operating costs. There is no way to get around the loss of money. This is unlike other pro-

viders who will lose 1 percent of their profits. Let me repeat that a home health agency will not even be reimbursed their operating costs. With lower cost reimbursement rates, cost limits per discipline, and now Gramm-Rudman, many agencies will not be able to survive and will simply be closing our doors.

Sadly enough, these are not our only problems with reimbursement. Home health agencies are subject to a pre-payment review. We submit summaries of the care we provide per patient and based on fiscal intermediaries' reviewer determination, the claim is either paid or denied. Previously, as long as an agency had less than 2.5 of their total visits per year denied, they maintained a favorable waiver status and some or all of the denied visits were paid for. This allowed us some insurance against denials that may have been made as a result of a reviewer's error and many of the denials made were based on a reviewer's interpretation of the Medicare regulations which differed from the interpretation of the agency who provided the care in good faith. We have recently been informed that we will no longer have the protection of a favorable waiver status and that all denied claims will be agency liable.

Like most other agencies in Tennessee, our agency has received some denials. We had maintained favorable waiver status in all of our agencies, but now without the insurance of waiver status any denials received will be very real problems for our agency. Our only recourse when denials are received is the reconsideration progress, which brings up still another new major problem for our industry. We have recently been informed by our Tennessee fiscal intermediary that funds for the reconsideration process have been exhausted and that any reconsiderations requested will be placed on the shelf for an indefinite period of time.

At this time I would like to tell you about our Mr. R. He was a victim of a neuromuscular degenerative disease. He was sent home from the hospital diagnosed as essentially brain dead following a respiratory arrest. He was totally comatose, required an ice blanket to control his raging fevers caused by the lack of body temperature control from the brain injury. He had a tracheostomy which requires frequent suctioning and through which he required the delivery of high levels of humidified oxygen. He had a feeding tube through his nostril and into his stomach through which he was continuously fed and a Foley catheter for the provision of elimination. Initially, our nurses saw Mr. R on a daily basis. Our visits were decreased to three times a week and then two times a week and then one time a week for the continuous required observation and evaluation of his condition and assistance with his very complicated care. We received a denial for all oxygen tanks in excess of only one per month, which would not even sustain his life. We also received a denial for suction cathethers in excess of 12 per day. On many days Mr. R secreted excessive amounts of respiratory secretions that had to be suctioned in order to maintain a patent airway so that he could even breathe. We were also denied many of our nursing visits as our intermediary felt that we saw him too often and that some of the visits were provided in the form of maintenance or preventive care. We have thousands of dollars upaid on Mr. R's claim for care that was provided as long ago as February 1984. Our initial reconsideration was filed in May 1984 and still we

have had no response. Now we learn that there will be no response to our request for reconsideration for an indefinite period of time.

As you can see, it would not take many denials of this nature to cause major problems for the agencies in our industry today.

Before I stop outlining problems with our current system, my colleagues here today would not forgive me if I did not at least mention that the paperwork required by Medicare is extremely burdensome, time consuming, costly, and duplicative in nature and that is where a lot of our money is spent.

Suffice to say, I could not agree more that we have a very great need for more comprehensive services for those faced with catastrophic illnesses or accidents. Many of these patients currently experience large gaps in the provision of services due to the limitations of our current system. Unfortunately, these gaps will grow even larger if the recent and devastating problems that we are facing in our industry today are not dealt with and dealt with swiftly and it will be the patients and their families who will suffer.

I very much appreciate the opportunity to express my views today and on behalf of the home health industry I heartily thank you both for addressing this situation.

Ms. LLOYD. Thank you.

Mr. PEPPER. Well, Ms. Worley, I am sure everybody has been deeply moved by the excellent statement that you have made and the problems of the individuals you have presented and the Government's response. We must somehow or another bring the Government agencies closer to the people so they will know more of the facts. I just cannot believe that the Government of our country wants to do to those people what the policy did to the people you have told us about. We will ask some more questions in 1 minute.

Mr. PEPPER. Our last witness of this excellent panel is Ms. Betty Leake, ex-director of the Home Visiting Nursing Service. We are glad to have you, Ms. Leake.

STATEMENT OF BETTY LEAKE

Ms. LEAKE. Thank you, Congresswoman Lloyd and Chairman Pepper. I would like to just follow up with what my peers here have said. I agree with everything they said and my list could be as long as Ms. Worley's or even longer. Those are daily events that happen to us. We serve 25 counties in east Tennessee. Some of our counties do not have Federal roads or have never had a railroad, so that is how remote some of the counties are that we do serve from my agency.

Eighty percent of the needs that we meet for these people are due to physical limitations due to their aging process such as hearing—loss of hearing, sight, and their mental functions. For the majority of our patients that we serve to have to spend $2,000 on health care would deplete their total assets.

The present Medicare law is interpreted at least 50 different ways and I would like to see the legislation that you and Congresswoman Lloyd are addressing to somehow ensure that it can only be interpreted the way it is written. That has been a problem—a severe problem for home health agencies in particular the last 3

years, inconsistency in interpretation of the regulations and also the Medicare law.

I believe that the cost per visit of any agency would greatly be reduced if the home health agency working with the physician could establish the plan of care to meet the patient's real needs and as Ms. Pope said earlier, those needs—the majority of the needs that the people have in the area I serve are supportive services—not services for acute illnesses and that has been one of the problems with the present Medicare coverage. It does not cover long-term illness like we are talking about and home health regulations were written to cover a longer term illness, but those regulations have been turned around and interpreted to treat an acute illness which is certainly not safe and the home health agency cannot provide quality acute care in the home. We do not have the equipment nor the supplies to do that.

I would like to mention the 1-percent reduction in cost that we were given this month. My agency is a private and nonprofit organization. Our cost was reduced 1 percent, which means we are trying to operate on 99-percent reimbursement. I do not think we can do that longer than 3 months, for an agency that did 50,000 visits last year—we served 50,000 constituents last year in the 25-county area. If something is not done to give us some relief, those people will go without care in the 25-county area that we serve.

One of the problems that I feel as a registered nurse that has not been addressed in previous interpretation of the regulations is that all levels of health care have been lumped into one reimbursement cost. By that I mean that home health care—when a regulation comes down, home health is limped into hospital care and there is no comparison to home health care, nursing home care and hospital care when it comes to reimbursement interpretations. Thank you.

Mr. PEPPER. Thank you very much, Ms. Leake, for your excellent statement. Ms. Lloyd, would you begin your questioning?

Ms. LLOYD. Certainly. You have pointed out the need that we have for catastrophic and long-term care and filled in some of the gaps that have not been addressed. I hope these hearings that we are having here and elsewhere across the Nation will raise the awareness and the conscience of the American people to the great need that we have of caring for our seniors—our seniors who went through the hard times of wars and depressions to make a better life for all of us. Indeed, we do want to make this world a better place for all men and women to live and for young people to be educated and trained, but we must not forget our responsibility as a Nation and as individuals to our senior citizens.

Certainly this need has been brought up today. All of your testimony has been most excellent. We are grateful to all of you and I have worked over the past 12 years, Mr. Chairman, with these people. Of course we have seen enormous gains in the programs that have been formulated, but there is much more that needs to be done. And, Doke Cage, you have been one of our great pioneers in providing for good care for nursing home patients in our area. Something that really concerns me as I see you working as a great, self-giving person, is that it seems to me you are having to care for sick patients in your area longer. Is that correct?

Mr. CAGE. Yes, it is, plus the fact that quite often we find ourselves faced with a situation where we think we are making progress with individuals, but someone else makes a decision that progress is not occurring fast enough and as a result the benefits are denied that individual whereas we felt that if we had a little more time to work with the patient that we could get them back out into the community, but now we find that they are going to be dependent upon nursing home care for the rest of their lives when we felt that there was potential there.

Ms. LLOYD. Is there a problem for Medicaid supported patients to get into our nursing homes?

Mr. CAGE. It is very difficult for a Medicaid-supported patient to get into a nursing home. It is not difficult for a Medicaid-supported patient to stay in the nursing home and that is what I had in mind when I made reference to the fact that the program actually supports institutionalization, that they are placed in that position for the rest of their natural life simply because that if they get out of the nursing home—they are permitted to stay in the nursing home and although they may feel they may—we may think that they are eligible for some sort of discharge planning, their concern is that if I get out of the nursing home I cannot get back into the nursing home if indeed I have this kind of need. Therefore, we think that there need to be some sort of revision of the program that would make services more accessible and at the same time give the providers the encouragement and the patient the encouragement to go back into their—that independent lifestyle as quick as they possibly can.

Ms. LLOYD. You know, one of the concerns that I have that has been expressed earlier is that we do have two tiers of care. Either you have to be a wealthy person or you are reduced to a pauper status in order to have decent care. I do not think that this speaks well of our government, to have such a disparity in Government policy, and this is one of the areas that we are concerned about.

Mr. CAGE. I think perhaps maybe this is—however, I think some of the others on this panel today have made mention of the fact that it is very difficult to stay in business if indeed your reimbursement is less than your cost and that the only alternative is to find some way to supplement that or go out of business completely. Certainly being in a publicly operated nursing home and being supported with the local tax dollar—perhaps maybe what I face is different from what someone in the private sector would face, but it goes without saying that if indeed those individuals in the private sector find that the reimbursement for a Medicaid recipient is not adequate to defray the cost of providing that service then they must limit the number of patients that they can accept with that payment method.

Ms. LLOYD. Nothing is free and certainly you have to pay your bills as do other people. I appreciate your input and your testimony. It has been great.

Bob Loflin, as you said in your testimony, somebody has to pay the bills, and this is a cost that has been passed on to private patients in your area as you provide the service. To me, it seems that these are the people who really cannot afford to be making up the difference and we are going to have to look at other areas.

'Mr. LOFLIN. We are no longer able to depend on the insured Peter to pay for the uninsured Paul because people in the private side now and the insurance companies are saying we will pay for what we need and for our employees, but we are not going to pay the extra because there is where we have been picking it up. I would say to you in round figures approximately 25 percent of what some charges have been across the country have been to supplement what you have not been getting otherwise, including Medicare, Medicaid or med-gaps or medically indigent. You just have not been getting it, so you are shifting it. We are no longer going to be able to shift it and our concern is within the Medicare Program—I will point out one thing here in particular and, Congressman Pepper, I know you are certainly aware of this one, in Tennessee, Medicaid does help to pick up that insurance element for the people who are poor, but you just got through saying, Congresswoman Lloyd, that the problem is we are taking care of those who have it and those who really do not have anything. Our problem is those who are in-between.

You have people that you heard here today before us that they were making a good living, you know, their husbands were well, they were well, they had jobs, but then you get down to the point of the illness itself and the cost aspect of the job itself just really takes everything from them and there is where we are finding great concerns is the people that are in-between. There is the catastrophic side right there and it is not just the elderly, it is the middle class and when you hve spent down to where you do not have anything else to spend, Congressman Pepper, you spoke of this, we are all going to be in bad shape and we think theire needs to be a reform area.

The things you are shooting for are the things we recognize. I will just say to you it is not just Medicare, it is across the board and we have got great concern for the medically indigent. The medically indigent, as we define that, are not the people who are totally poor. They are the people right above that. They can pay for their housing, they pay for their clothing, they pay for their food and maybe transportation, but they do not have any way to pay for their health care and that is difficult and there is where the gaps have got to be filled. So there is great concern along those lines. We are not going to substitute anymore people that are sick, we cannot. We cannot continue to pay the extra to take up the slack and there is the problem that we are faced with in the hospital industry.

Ms. LLOYD. Thank you very much. Peggy, approximately how many more people could you take care of and keep out of nursing homes at the present time if you were more adequately funded with a catastrophic program such as we are visualizing?

Mr. MEIER. If I had more money to put into assisting people with the Meals on Wheels or homebound delivered meals and this sort of thing, in our county alone—oh, you are asking a figure and I—it is an estimate, Congresswoman, because it has been a dream and it is one of those dreams that I have not put a lot of time into. I would say probably about another—Millie, $10,000?

VOICE. Approximately.

Ms. MEIER. Yes, $10,000 in our budget. Our Federal budget now in our county for the elderly programs is around $155,000 before the 4.3-percent cut. So—and we are serving meals—170 meals a day, of which a good portion of those are home delivered meals and then my services, which are information gathering and helping families get the services that they need, get to the home health care agency that they need or to the nursing home, the hospital, or wherever are a smaller portion of that. So it would not take a great deal. Now as far as the adult day care center, if we were to put an adult day care center into our county that is another item and that would take another $50,000 to get it started initially and hopefully some of those fees would be picked up by people on a sliding fee scale.

Ms. LLOYD. Compared to the cost of nursing home care, that would be a good investment.

Mr. PEPPER. Thank you very much, Ms. Lloyd. I was born and reared in Alabama and my folks have lived in the South since before the Revolutionary War. In the South generally, before Roosevelt came in, about the only care that we had, at least a lot of the South, was what was called the poorhouse and poor indeed it was in the service of impoverished people.

I remember I was reading an account in a newspaper not long ago that about 1930 in one of these poorhouses, some poor place over the hill somewhere, a lady one day approached a man with a hammer in her hand and cried out to this man. She said, "take this hammer and knock these old teeth out, they are killing me." That was characteristic of the quality of care that was provided generally in those so-called poorhouses. It was a last resort. But, then President Roosevelt came in and the conscience of the Nation began to concern itself with how to treat the needs of the people more adequately. One of the things that President Roosevelt came up with was Social Security.

I was the second man in Florida to propose old age pensions. I was running for the Senate in 1934 and I began to hear that a young opponent of mine was talking about old age pensions. Well, I had not thought about old age pension, as a matter of fact, but my reports were that he was getting a good response from the older people so I got a good lawyer friend of mine to check upon this thing of old age pension, is it something that I should advocate? He checked up on it and found out that before the end of the last century it was decided what we would call old age pension, or Social Security, in Germany and most of the advanced of Europe had already developed some kind of a Social Security program before President Roosevelt initiated it in our country in 1935. I went to the Senate in 1936. Social Security took effect in 1937. So I got there 1 year after it was inaugurated in the law and 1 year before it took effect. Except the 12 years that I was out of Congress, from 1951 to 1963, I have been there all the time when the Social Security Program has been in existence.

Now the average check of the 36 million people that are covered by Social Security is about $400 a month. That is less than $5,000 a year. The information I have is that at least half of all the 36 million people who get a Social Security check every month rely upon that check for at least half of their total income. Now remember

that is $400 a month, less than $5,000 a year, so you can see all that it means and we are sure that is all it means. There has been no better friend to Social Security than your great Representative here, Marilyn Lloyd. As important as that is, you can see how it earmarks the needs for us taking another look at what we have done.

In 1965, successors of the Roosevelt period, I was in the Congress at that time, passed Medicare and we had a place to send to the hospital people who were sick for short-term care. You cannot get in the hospital if it is long-term care, under the Medicare Program, it is only for people who are ill with a disease that can be properly cured within a short period of time. Now you can see if you take into account all of the medical needs of the people in the United States, that is grossly inadequate.

We have talked about Alzheimer's disease and Parkinson's disease and stroke and about heart attacks and about arthritis and the like, but there are two others. One is long-term care. The name of our subcommittee is Health and Long-term Care. We have been for years—Marilyn has been one of the most eminent figures. We have working on the matter trying to figure out how to provide long-term care. People that do not need to be in a nursing home where you have got a staff of doctors and everything just so they live in a decent place with reasonable professional care and nourishment for them and some general medical supervision. They just need loving care for the rest of their lives. We have not yet got around to doing that. We are trying to provide such care in the bill that Ms. Lloyd and I are proposing to the Congress. So that is another aspect, people who do not have anything, they are sleeping in the streets. They do not have any place to live. We have a problem to deal with them.

And then there is another category. A lady, not long ago, sat down by my desk in Washington. She said, Mr. Pepper, if you will look at my eyes you will see they have already turned yellow because I have liver disease and they tell me that if I do not have a transplant within the next six or nine months, I will be dead in the next 12 months. She said she had been to some of the hospitals where they perform these transplants and they told her it would cost probably $150,000 to have it done. She had been appealing to the public and had been able to raise $45,000. But how was she going to raise the rest of it? She said, I have been working on it now 2 or 3 months and I am getting worse everyday. She said, do you know of any Federal help I could get? Well Mr. Stockman, the Director of the Budget, was in office at that time. He is a very knowledgeable man about the Government. I saw Mr. Stockman and told him about this case and said do you know of any Federal program under which that lady can get any help? He said, no, I do not know of anything. Well I said, check up on it and call me back please. He called me back and said I do not know of any program to give anybody like that any help. Well, to make a long story short, the lady finally got a donor of a liver from Texas. She was then living in Houston. She had formerly lived in Florida. She got a big hospital in Boston to accept her for much less than they usually charge for that kind of operation. She has had the operation. Thank the Lord, more people contributed to her. Now she is trying

to raise $15,000 a year, which it takes to fight the tendency of the body to throw off any organ that is injected into the body by transplant. So she has still got a problem with another $15,000 a year. I thought about that case.

Imagine how many people there are in the United States that need transplants of one sort or another to live? Those operations are terribly expensive and you, of course, have to be at the right kind of place to get it performed. By the way, she told me, and I honor your great State of Tennessee, she said, she found a hospital in Tennessee, I remember, where they would do the operation cheaper than they would have charged her in the East. She felt very good about that. Then, for some reason she decided to go to the Boston hospital and they agreed to take her and perform the operation for a smaller amount.

But what we are talking about is just a few of the challenging cases that are in the population of our country. Mr. Loflin here tells us that under Medicaid where the scope of coverage is generally determined by the State, you only take care of 36 percent of the people who are impoverished. Who is going to take care of the others? They are human beings. In America we believe that God gives life only and that life, if it can be continued by medical facility or skill, is sacred in every human being whoever it is. Somehow or another, we have to provide a way by which that can be done in the American way.

I don't want anybody to start talking about socialism to me. I am not in favor of any kind of thing but Americanism, but I know that the marketplace today—these cases like you have heard here today are demanding that our Government look again at what we are doing until it is more complete and comprehensive in its coverage of the needs of the people. That is what Marilyn Lloyd and I are doing in this case.

We have tried. We have had a lot of contact with the big insurance companies in the Nation. They are moving into this field and I admire them for doing it. But, most of their coverage is through employers. So a big company like Sears & Roebuck, say, could insure all employees of, say, Sears & Roebuck and with fairly a comprehensive plan. But everybody does not work for a big company. A lot of people work for little companies and are not able to make these contracts, and we need more.

We want to try to have our program administered by private enterprise. I can understand maybe the Government contracting with an insurance company to render the service or with a hospital association and the like—the main job of the Federal Government is to see to it that everybody is treated fairly. We want the efficiency that comes usually from private enterprise engaged in the operation. We know, as some of the witnesses have said, it is not just the elderly who need help. It is the whole middle class and a great many of the very poor.

As you said, Mr. Loflin, Medicaid in Tennessee only covers 36 percent. I suspect that is about as good as any other State covers, too. We have a long way to go. But, I am hoping that by beginning to make some progress, taking what we have done already and reshaping it, then maybe we do a better job with the money that we are now spending. If we need to add onto the cost a little bit more

to meet the needs of the people, then we will have to consider that problem. But what we are thinking about right now as far as this particular bill goes is cost neutral. We simply propose to take the money that Medicaid is spending, take the money that Medicare is spending, take the money that the people are spending for Medigap insurance to supplement what they get from Medicare and the other public contributions, put it all together, rechannel it, be more efficient in its administration. We think we could get better results for the people of the country, but sooner or later we have to extend this program to include everybody.

I think about, you know, the old saying, but by the grace of God I go, the man said as he saw a tramp walking by the window. I thought about that. Suppose some of us were involved in the situation some of these victims are. How many in this audience today would be able to support the cost of nursing homes without Government aid in a long and serious illness? So we have come here today to let you hear the need for this kind of legislation. We have come to let you know what it is we are trying to do, ask if you can do so conscientiously, to give us your support by conveying your sentiments to your Members of Congress.

And, incidentally, this hearing has been recorded. It will be made available to Members of Congress so they will get the benefit of this hearing—this excellent hearing that we have had today and the record will be open for a period of 2 weeks for any additional statements that anyone might wish to make. Just send them in—addressed to your office?

Ms. LLOYD. To my office here in Chattanooga.

Mr. PEPPER. Send it to Ms. Marilyn Lloyd's office here. She will see that they are properly included.

I want to congratulate you, Ms. Lloyd, upon the excellence of this hearing today, the wonderful testimony all given us and this fine audience manifesting your great public interest in this subject, your kind attention, and your evident support of what we are trying to do. I want to compliment you and I want you all to know that this lovely lady right here is the staff director of our Subcommittee on Health and Long-Term Care and as always, had a very large part in the excellence of our hearing. We thank Katy also, for her kind assistance, thank all the media for the assistance and cooperation they have given us and all the people who have had a part in this hearing and especially Marilyn.

Ms. LLOYD. Thank you very much, Mr. Chairman. I want to thank you for being here. It is one of the great days of my life and my district as well. We love you and we are grateful to you. I also would like to thank Kathy Gardner for the good job she has done, members of my staff and you that have testified before us today.

I would like to close our hearings today with the proclamation, Mr. Chairman, that was just handed to me that the people in the audience have all signed here. It says,

Proclamation to Congressman Claude Pepper, World Citizen. We the people who affixed our signatures to this small token of appreciation unanimously applaud long and loud your efforts and achievements championing the cause of the elderly, the poor, the hungry, the homeless, and the ill. The American people will never be able to reward you enough for the legislative leadership and the continuing legislative battles you fought and continue to fight. We believe that there comes upon Earth every century or so mortal men such as Edison, Gandhi, King, Lincoln, Jefferson.

America and mankind surely will be blessed when another Claude Pepper comes along. God bless you and give you continued good health.

The people in the audience signed it, so we thank you today.

[Whereupon, the hearing was adjourned at 12:09 p.m.]

APPENDIX

TESTIMONY FOR THE HEARING ON
CATASTROPHIC HEALTH CARE--
THE TENNESSEE PERSPECTIVE
CONGRESSIONAL HEARING
Subcommittee on Health and Long-Term Care
of the Select Committee on Aging
Chattanooga, Tennessee
March 27, 1986

Thank you for the opportunity to present brief testimony on this important issue. I am Martha Butterfield, R.N., chairperson of the Chattanooga-Hamilton County League of Women Voters Community Task Force on Uncompensated Health Care. The Task Force was composed of representatives of various community organizations and individual citizens.

The committee identified multiple reasons for the crisis in uncompensated health care in this community. One of the major problems was the need for catastrophic health insurance.

Children, young adults, the middle-aged and the elderly all are affected when sudden, critical or chronic health problems occur. These illnesses drain the financial resources of an individual and family.

Frequently, insurance is inadequate, or does not cover the illness at all. A family with a one year old child who has a chronic neurological problem can't get insurance. A 45-year old with cancer has used up the allowed hospital days on his insurance policy. An elderly man delays returning for follow-up health car for his heart problem because he could not

afford it. These are just a few examples demonstrating the need for catastrophic illness insurance.

And then there are those who are able to pay very little, if anything, toward their health care. These persons are either "indigent", or they are unemployed, or employed part-time without the benefit of insurance. The cost of health care for these individuals is reflected in the "bad debt" column at health care agencies; higher hospital rates and local taxes, however meager, for indigent care.

When funding for health care is limited, or absent, it results not only in personal financial strain and declining health, but also added burdens to society. The need for various social services increases as does the need for nursing home beds. The result is greater health care costs, and a rise in societal costs. Which would be more costly--to pay for the necessary insurance or to pay the costs which accrue as a result of inadequate catastrophic health insurance.

Catastrophic health insurance and/or risk pools for the uninsurable are needed. The funding source could be from the public sector, the private sector, or a combined effort to meet the need that is there.

Thank you for the opportunity to address this issue.

Mrs. Martha Butterfield
2936 Ozark Road
Chattanooga, Tn. 37415
(615) 755-4644 (office)
(615) 875-5513 (home)

[redacted] House of Representatives
[redacted]
[redacted] Term Care
[redacted] Insurance:
[redacted]"

My name is Becky [redacted] Care Ombudsman for the ten county area of [redacted], I seek to resolve complaints, problems, and concerns brought to [redacted] by nursing home and boarding home residents, families, staff of the [redacted] term-care facilities in my district, and other professionals in the [redacted] network.

The clients I serve are the frail elderly-over sixty, afflicted with one or more chronic illnesses, and often institutionalized. Almost daily I receive calls from a panicked family member or spouse of a loved one who is hospitalized and the "Medicare coverage has run out." There is no need for "skilled" care in a nursing home (the only level of care reimbursable by Medicare) and no one able to continue to provide the necessary care. There is no money to pay for in-home services, or for expensive intermediate or custodial care in a nursing home. Costs for nursing home care in this area ranges from $1300-1700 a month plus medicines and doctor visits. There are a few "private pay" beds available, but there is about six to eight month waiting period for a Medicaid bed. These callers are usually in a state of shock having discovered that neither Medicare nor their insurance policies cover this level of care and they are left to fend for themselves as they try to make their way throught the system. Medicare and supplemental policies provide good coverage of acute illnesses, but once an individual's medical condition has stablized, or has deteriorated to the point that there is no hope for rehabilitation, there is no more coverage under these plans. Even if the patitnet were able to go home, Medicare and most supplemental policies would not cover expensive prescription medicines, glasses, dentures, hearing aids, and routine physician visits.

When the Medicare Program was enacted in 1965, it was assumed that this piece of legislation would enable individuals to have access to good health care, regardless of their ability to pay for such care. Senior citizens breathed a sign of relief as they believed Medicare would offer comprehensive coverage for medical costs. Sadly, that dream has been shattered as more and more older American's confront rising health care costs, and an increasing number of services not covered by Medicare. The Diagnosis Related Groups System (DRG's) was designed to encourage cost-effective delivery of hospital services and may have helped the government to save money, but in many cases has hurt the quality of medical care for older people. DRG's have helped to hold down costs, made doctors and hospitals more cost conscious, and limited hospital admissions and stays, but has created a trade-off between controlling costs and maintaining quality of health care. Reimbursement under DRG's does not take into account costly treatment for complications or severity of illness. Decisions to admit or keep a patient are too often based on financial reimbursement and not medical need. Many patients who are denied admission or sent home too early will need to return and be re-hospitalized when they are sicker and in need of costlier care. I recommend an evaluation of this system including identification of effects of the system on vulnerable groups such as the elderly, disabled, and mentally ill people with medical problems, and effects on the health care system.

Statistics show that 5% of the nation's elderly are in nursing homes while a large number are cared for at home by family members. We must find a way to assist these care providers and encourage them to continue to provide this care by increasing Medicare coverage to include in-home services such as personal care (bathing, dressing, etc.) even when there is no "skilled" need, respite care, day care, portable meals, and transportation as well as hearing aids, dental care, and eyeglasses.

In his State of the Union address, President Reagan addressed the need to provide catastrophic health care coverage to the elderly which is encouraging. This plan must do more than fill the gaps for acute care coverage - it must be designed to cover those who fall through the cracks, and it must be a plan that will assure reasonable access to good health care as well as offer protection for any of us who may fall victim to a catastrophic and expensive illness.

Respectfully Submitted,

Becky Ingle

Becky Ingle
SE TN Long Term Care
Ombudsman
1100 Gateway Avenue #1302
Chattanooga, TN 37402

HOME AIDE SERVICE
P.O. Box 56
Clinton, Tennessee 37716
(615) 457-4263
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April 3, 1986

Congressman Claude Pepper
Select Committee on Aging
Subcommittee on Health and Long-term Care
U.S. House of Representatives
Washington, D.C. 20515

Dear Congressman Pepper:

It was with special interest that I attended your hearing on Catastrophic Health Insurance last Thursday in Chattanooga. As the Director of Home Aide Service of Anderson County, I am keenly aware of the inadequacies and inappropriateness of many of our health care systems. It seems that the system we are currently using is 'foolhardy' in supporting more costly health care which does not address catastrophic or chronic needs.

As you know, institutional care is the most costly way to sustain life and yet does not always offer much to the quality of life. According to the National Council of Home Health, the average daily cost of hospital care is $320.00 per day. Nursing Home care averages $60.00 per day, and skilled Home Nursing care averages $50.00 per day. We have found with Home Aide Service a cost-effective alternative that adds to the quality, dignity, and independence of life for the elderly. With supportive services such as ours, many persons are maintaining themselves in their homes for an average cost of $25.00 per week. Few persons wanting to remain in their homes need daily skilled nursing care. Many can get by with assistance one to two times a week for personal care, meal preparation, laundry, and shopping. Even with a daily visit of one hour, the cost would be one-third of nursing home care.

Ninety percent of our clients are homebound. Many are confined to wheelchairs, or are bedridden. Seventy-two percent are 75 years of age or older, and 59% have fixed incomes below the poverty level. With local government funding and donations, we have been able to provide services on a sliding scale to all income levels. It has been a constant struggle to keep this funding available. This year we see the funds cut even further and a critical situation in chronic health care. Many will be terminally neglected. For those that are compelled towards Nursing Homes, an even greater crisis will occur due to the lack of bed space.

On behalf of the clients of Home Aide Service, I urge you to continue the valuable work you are doing. If there is any way I can be of assistance to you or your committee I will be available. Home Aide Service is a system that works and offers hope to our chronically ill. If this agency and others like it are allowed to die from lack of funding it would be another loss and a disaster to the aging population of this community. It is the type of system that offers a cost effective solution to our elderly.

Sincerely,

Roselyn M. Ganser, R.N.,C.

Roselyn M. Ganser, R.N.,C.
Executive Director

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31 March 1986

U. S. Representative Claude Pepper
Congress of the United States
Washington, D.C. 20000

Dear Congressman Pepper:

It is always a pleasure to read and hear of your efforts on behalf of the aged. This clipping appeared in a recent Nashville Newspaper.

I would like very much to emphasize to you another disaster area for the increasing number of aging people - the Long Term Nursing Home.

Sooner or later the residents of these homes are supported by Medicaid (unless they die before using up all their financial resources). Medicaid pays the nursing home in Tennessee a pittance: $32.65 per patient per day. This sum must cover food and board, salaries, maintenance of the facility, mortgage costs and an income for the owner-individual or chain. As a result wages are bottom. Nurses Aids receive minimum wages with no benefits or perquisites. They are for the most part untrained and many are on welfare. The turnover rate is as high as 200% per year. These aids are the ones who do hands on care of the residents. They are over worked and have no time for warmth.

I would be glad to participate in your hearings and help you with them. As a Vanderbilt Medical School Professor I teach medical students and house officers in a nearby nursing home.

I am sure you realize that medical care of the residents in a nursing home is poor. Medicaid pays a maximum fee of $10.00 per month to an attending physician for care of his patient in the nursing home no matter how often he visits. Many private physicians do not, therefore, follow their patients into nursing homes. As a result there are physicians who make a large part of their living being responsible for many patients in nursing homes. One in Nashville sees 500 in addition to a busy practice. He can barely keep up with the paper work. He is a hard working compassionate man but he can't have time to see his nursing home residents often.

Let me help if you wish.

Sincerely yours,

F. Tremaine Billings, Jr., M. D.
Clinical Professor of Medicine

FTB:mea

TESTIMONY OF BERNICE H. LONG

WHEN ONE GIVES TESTIMONY BEFORE A HEARING SUCH AS THIS, ONE USUALLY DRAWS UPON THEIR PERSONAL OR FAMILY INVOLVEMENT WITH THE SUBJECT ADDRESSED. WHEN I TESTIFIED BEFORE A SENATE CONGRESSIONAL HEARING IN WASHINGTON LAST YEAR ON OSTEOPOROSIS, IT WAS BECAUSE I HAD OSTEOPOROSIS AND HAD SUFFERED A RESULTING SPINAL FRACTURE.

TODAY, I CANNOT GIVE PERSONAL EXPERIENCES OF MYSELF OR MY FAMILY WITH CATOSTROPHIC ILLNESSES BUT I CAN EMPHASIZE THE CONCERNS OF MANY OF THE TWENTY MILLION MEMBERS OF THE AARP.

DURING THE YEARS 1984 AND 1985 I HAVE BEEN THE STATE COORDINATOR OF HEALTH SERVICES FOR TENNESSEE, APPOINTED BY THE AARP, AND MY WORK TOOK ME ACROSS TENNESSEE FROM MEMPHIS TO BRISTOL, AS WELL AS THROUGHOUT THE UNITED STATES, DEALING WITH A WIDE RANGE OF HEALTH PROBLEMS AFFECTING OUR SENIOR CITIZENS.

EVERYWHERE I WENT I LEARNED FROM THE PEOPLE I SPOKE TO, AND WITH, THAT THERE IS A MOUNTING EPEDEMIC OF FEAR AND OUTRAGED CONCERN AMONG THE SENIOR CITIZENS OF THIS COUNTRY AS TO WHAT WILL HAPPEN TO THEM IF THEY ARE STRUCK DOWN BY ONE OF THE CATASTROPHIC ILLNESSES. THEIR FRIGHT IS INFLAMED BY THE KNOWLEDGE THAT THEIR LIFE SAVINGS, THEIR HOMES, AND THEIR MODEST RETIREMENT INCOMES COULD BE SWEPT AWAY AND SWALLOWED UP BY THE CURRENT HEALTH CARE SYSTEMS BECAUSE THEY ARE WITHOUT MEDICARE AND SUPPLEMNTAL INSURANCE PROTECTION FOR SUCH MEDICAL CATASTROPHIES.

LAST FALL I SPOKE AT SEMINARS IN EIGHT CITIES ACROSS TENNESSEE ADVOCATING THE ESTABLISHMENT OF A MEDICARE ASSISTANCE TRAINING WORKSHOP WHICH WOULD TRAIN VOLUNTEERS TO PROVIDE ASSISTANCE TO SENIOR CITIZENS IN THIS STATE IN FILING THEIR MEDICARE CLAIMS OR WITH PROBLEMS CONCERNING THEIR MEDICARE OR MEDICAID BENEFITS. EACH SEMINAR WAS ATTENDED BY REPRESENTATIVES FROM AARP CHAPTERS IN ALL THE SURROUNDING COUNTIES. WHAT BECAME VERY APPARENT TO ME DURING THE MEETING DISCUSSIONS WAS THAT MEMBERS OF THE AUDIENCE WANTED TO ASK QUESTIONS AND TALK ABOUT OTHER ISSUES DEALING WITH MEDICARE, ESPECIALLY THE GAPS IN MEDICARE COVERAGE. THEY PROTESTED THE GAPS THAT DO NOT ASSIST SENIOR CITIZENS WITH THE NECESSITIES OF EYEGLASSES, DENTAL CARE AND HEARING AIDS. THEY PROTESTED THE MEDICARE LIMITATIONS ON NURING HOME AND IN-HOME CARE FOR EXTENDED CARE OF THE CHRONICALLY ILL ELDERLY. BUT MOST OF ALL, THEY PROTESTED THE LACK OF PROTECTION BY MEDICARE AGAINST THE BANKRUPTING TENACLES OF OUR HEALTH CARE SYSTEMS ON WHICH WE MUST DEPEND FOR THE EXTENDED CARE OF OUR SENIOR CITIZENS WHO HAVE BEEN STRUCK DOWN WITH DEADLY CANCER IN ALL ITS MANY FORMS, DEBILITATING HEART CONDITIONS, THE CREEPING ALZHEIMER'S DISEASE, THE PARALYZING STROKES, AND MANY OTHER CATASTROPHIC ILLNESSES.

THEY WERE DEEPLY CONCERNED PEOPLE WHO RECOGNIZED THAT THEY WERE NOT IMMUNE TO THESE PROLONGED ILLNESSES AND AGAINST WHICH THEY HAD LITTLE OR NO PROTECTION FROM MEDICARE. OUR SENIOR CITIZENS ARE FRIGHTENED! I, TOO, AM FRIGHTENED.

PEOPLE HAVE CITED EXAMPLES OF THEIR CONCERN TO ME, MANY OF WHICH WERE FAMILY ORIENTED AND WHICH I WILL NOT ATTEMPT TO INJECT INTO THIS HEARING. BUT SUCH EXAMPLES DO EXIST - NOT ONLY IN TENNESSEE BUT NATIONALLY.

I HAVE BEEN QUESTIONED OFTEN ABOUT SUPPLEMENTAL INSURANCE. RECENTLY A WOMAN TOLD ME THAT SHE HAD DROPPED SEVEN HEALTH INSURANCE POLICIES AND RETAINED ONE. SHE WAS ONE OF THE THOUSANDS OR MAYBE MILLIONS OF SENIOR CITIZENS WHO THINK THEY ARE CLOSING THE MEDICARE GAPS BY PURCHASING NUMEROUS POLICIES. THEY DONT UNDERSTAND THE FINE PRINT THAT SAYS IN CASE OF DUPLICATE COVERAGE, ONLY ONE POLICY PAYS. AND EVEN THAT ONE POLICY DOES NOT PROTECT THEM ON EXTENDED NURSING HOME OR IN-HOUSE CARE FOR CATASTROPHIC ILLNESSES.

ON THE BRIGHTER SIDE, WE KNOW THAT FOR SUCH ILLNESSES WHERE THERE IS A REASONABLE AMOUNT OF RECOVERY, MEDICARE AND SUPPLEMENTAL INSURANCE CAN PROVIDE SUFFICIENT COVERAGE FOR THE POST-HOSPITAL CARE COSTS. BUT WHAT WE ARE TALKING ABOUT TODAY ARE THE CHRONICALLY ILL WITH LITTLE HOPE OF RECOVERY OVER A LONG PERIOD OF TIME WHO HAVE LONG CEASED TO RECEIVE ANY ASSISTANCE FROM MEDICARE OR SUPPLEMENTAL INSURANCE AND WHO MUST FACE ALONE THE SOARING COSTS OF STAYING ALIVE.

IN A MEETING DISCUSSION on this subject, A WOMAN REMARKED TO ME - "MRS. LONG, IF I UNDERSTAND ALL THIS CORRECTLY, IT SEEMS THAT I WONT BE ABLE TO AFFORD TO LIVE AND I WONT BE ABLE TO AFFORD TO DIE - SO WHAT ARE THE ALTERNATIVES!" I COULD HAVE TOLD HER THAT WHEN ALL PERSONAL RESOURCES ARE EXHAUSTED AND A PERSON IS DECLARED PENNILESS, THEN MEDICAID, OUR SERVICE FOR THE POOR, TAKES OVER AND PROVIDES CARE, IF IT IS AVAILABLE! BUT I DID NOT THINK THAT WAS THE ANSWER SHE WANTED TO HEAR. THE TRUTH OFTEN HURTS. I TOLD HER THAT WE HAD GREAT HOPES THAT MEDICARE WOULD BE AMENDED IN SOME MANNER TO PROVIDE THE EXTENDED CARE NECESSARY FOR VICTIMS OF CATASTROPHIC ILLNESSES. I SAID THIS, WITH A SMALL INNER PRAYER THAT ALL THE EFFORTS AND ADVOCACY BEING MADE TO BRING ABOUT A NEW HEALTH CARE PLAN FOR SENIOR CITIZENS of this country WILL SOON RECEIVE THE SUPPORT AND APPROVAL OF THE UNITED STATES CONGRESS. MAY THEY LISTEN AND JUDGE THIS PLAN WITH THE DIGNITY AND RESPECT DUE OUR ELDER CITIZENS WHO MAY BE FACING THIS CRISIS.

March 27, 1986

PROCLAMATION

TO

CONGRESSMAN 'CLAUDE PEPPER' WORLD CITIZEN

We, the people who affix their signatures to this small token of our appreciation, unanimously applaud long and loud your efforts and achievements championing the causes of the elderly, the poor, the hungry, the homeless and the ill; the American people will never be able to reward you enough for the legislative leadership and the continuing legislative battles you have fought and continue to fight. We believe there comes upon earth every century or so mortal men such as Edison, Gandi, King, Lincoln, Jefferson; America and mankind surely will be blessed when another Claude Pepper comes along.

GOD BLESS YOU AND GIVE YOU CONTINUED GOOD HEALTH, we are,

Gratefully and respectfully,

George C Ewing
Peggy Mecey
Mary Ann Donaldson
Con Campbell
Marlene Thomas
Millie Betts
Jane Jane
Rose M. Ingram
Deborah Scott
Karen Campbell
Janice Patterson
Judy Bray
Sarah Dickson
Dixie Davis
James E. Wilcox
Edgar Reaves
Howard Massingale
Nancy A Leiber

(Editor's note: An additional 12 pages of signatures containing 254 names has been retained in Committee files, and may be viewed upon request.)